NOTE

This Microfiche meets the quality requirements of the American National Standard for Microfiche of Documents (ANSI PH5.9-1975). However, because of imperfections in the document from which it was made, it contains images that are illegible or difficult to read. The source document for this microfiche is the best copy that could be obtained prior to filming.

Congressional Information Service
Washington, D.C.

S. HRG. 101-229

ADOLESCENT SUBSTANCE ABUSE IN CONNECTICUT

HEARING

BEFORE THE

SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOLISM

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ON

REVIEWING THE ISSUE OF SUBSTANCE ABUSE TO SEE HOW PERVASIVE THE PROBLEM IS AMONG ADOLESCENTS, HOW THE PROGRAMS ARE WORKING AND WHAT CHANGES ARE NEEDED TO MAKE THEM WORK MORE EFFICIENTLY

MARCH 20, 1989
NEW HAVEN, CT

Printed for the use of the Committee on Labor and Human Resources

U.S. GOVERNMENT PRINTING OFFICE

20-137 WASHINGTON : 1989

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

S541-42.

20-137 O - 89 - 1

COMMITTEE ON LABOR AND HUMAN RESOURCES

EDWARD M. KENNEDY, Massachusetts, *Chairman*

CLAIBORNE PELL, Rhode Island
HOWARD M. METZENBAUM, Ohio
SPARK M. MATSUNAGA, Hawaii
CHRISTOPHER J. DODD, Connecticut
PAUL SIMON, Illinois
TOM HARKIN, Iowa
BROCK ADAMS, Washington
BARBARA A. MIKULSKI, Maryland

ORRIN G. HATCH, Utah
NANCY LANDON KASSEBAUM, Kansas
JIM JEFFORDS, Vermont
DAN COATS, Indiana
STROM THURMOND, South Carolina
DAVE DURENBERGER, Minnesota
THAD COCHRAN, Mississippi

NICK LITTLEFIELD, *Staff Director and Chief Counsel*
KRISTINE A. IVERSON, *Minority Staff Director*

SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOLISM

CHRISTOPHER J. DODD, Connecticut, *Chairman*

CLAIBORNE PELL, Rhode Island
TOM HARKIN, Iowa
BROCK ADAMS, Washington
EDWARD M. KENNEDY, Massachusetts
(Ex Officio)

DAN COATS, Indiana
ORRIN G. HATCH, Utah
NANCY LANDON KASSEBAUM, Kansas

RICHARD J. TARPLIN, *Staff Director*
STEPHANIE JOHNSON, *Minority Staff Director*

CONTENTS

STATEMENTS

MARCH 20, 1989

	Page
Morrison, Hon. Bruce, D-3rd District, Connecticut, U.S. House of Representatives	6
McConnell, Hon. Donald, Director Connecticut Alcohol and Drug Abuse Commission	8
Wheaton, Hon. Dr. Amy B., Commissioner, Connecticut Department of Children and Youth Services	13
Lynch, Brian F., CISW, Chief Executive Officer, the Children's Center, Wakeman Hall Adolescent Substance Abuse Program, Hamden, CT	16
Prepared statement	19
Bernier, Louise, Clinton, CT	24
Prepared outline statement	26
Higgins-Biddle, John, Director, Regional Youth Substance Abuse Project, NIDA Grant Recipient, Bridgeport, CT	28
Babor, Thomas F., Professor of Psychology, Department of Psychiatry, Associate Scientific Director, Alcohol Research Center, University of Connecticut Health Center, Farmington, CT	32
Prepared statement	36
Skerker, Veronica M., Department of Education, Hartford, CT	44
Prepared statement	47
Wright, Carol, Assistant Principal, Weaver High School, Hartford, CT	51
Calzetta, Gene, Madison, CT	52
Prepared outline statement	55
Gill, Latricia, Senior, Project Concern, Hall High School, West Harford, CT	57
Prepared statement	59
Crane, Beverly, Milford, CT	59

ADOLESCENT SUBSTANCE ABUSE IN CONNECTICUT

MONDAY, MARCH 20, 1989

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOLISM,
New Haven, CT.

The Subcommittee met, pursuant to notice, at 10:00 a.m., in the Wilbur Cross High School, 181 Mitchell Drive, New Haven, CT, Senator Christopher J. Dodd, (chairman of the subcommittee) presiding.

Present: Senator Dodd.

OPENING STATEMENT OF SENATOR DODD

Senator DODD. Good morning. I can hardly see all of you out there. It seems so far away. I would like to thank Wilbur Cross School for allowing us to host this hearing here this morning.

I chair the Subcommittee on Children, Family, Drugs and Alcoholism, which is a subcommittee of the Labor and Human Resources Committee of the United States Senate.

We have a lot of different hearings around the country on a number of different subjects, but one of the principal ones that the Committee focuses on, the Subcommittee focuses on is substance abuse among teenagers.

So I thought it would be a good idea to bring the hearing to Connecticut and take a look at what is going on in our own state, share with you some of the information on national data, and then hear from some of our principal people in the state involved in trying to improve the quality of our programs in treatment, in education, for people who have either, one, been caught in the web of substance abuse and are trying to get off of it or, two, provide good programs which will discourage other people who might be thinking about getting caught in that web from not ending up in those problem areas.

So I want to say welcome to the Subcommittee on Children and Families. It is a particular pleasure, obviously to be in New Haven this morning joined by students from Wilbur Cross High School. I hope that one of the first benefits of our work this morning will be a sense among all of you who are students here this morning that while we do not always do the best job, governments at the national level, at the state level and at the local level are trying, trying very, very hard to come up with good, intelligent programs that

will make a difference in your lives. So I am particularly delighted that all of you are here this morning.

In 1987, I became the chairman of the Subcommittee of the Labor and Human Resources Committee, as I mentioned. Our work has been devoted to helping create policy that respects and bolsters the place of the family in the United States today.

In this role, I authored a bill called the Act for Better Child Care Services, or the ABC Bill, and the Family and Medical Leave Act, to help American workers keep their jobs during times of family need and crisis.

In the past three years, I have also been a co-sponsor of two major pieces of legislation aimed at the problem of substance abuse.

The 1986 Drug-Free Schools and Communities Act included a provision which targets $20 million to demonstrate effective community-based programs.

These programs provide prevention, treatment and rehabilitation for high-risk youth who abuse—or are likely to abuse—alcohol or drugs. These projects are now underway.

And we are fortunate to have with us today Don McConnell of the Connecticut Alcohol and Drug Abuse Commission. CADAC is a Connecticut recipient of one of the Act's grants.

The most recent piece of major legislation is last year's Omnibus Drug Act. Sixty percent of the Act's funding is dedicated to education and treatment programs, while criminal and civil penalties for illegal use are also stiffened in that legislation.

The fact is that we have a variety of federal programs, as well as state and local programs, aimed at breaking society's addiction to drugs and alcohol. And that is of important note. But, so far, it seems we just cannot kick the habit. One reason is that programs which do more than require us to "just say no" are still not available or accessible to the people who need them the most.

That is why, as chairman of the Subcommittee, I am here today. I intend to embark on a thorough review—first at the state level here in Connecticut and then on the national level—on how pervasive the problem is among adolescents, how the programs are working and what changes are needed to make them work better.

Let me just share with you a few facts. Use of drugs and alcohol among children is happening more and more and earlier and earlier in their lives.

There is a false popular conception that the problem is limited to our cities, making it for many citizens "somebody else's problem."

Drug and alcohol abuse are not single victim problems; that is, the person who abuses a substance becomes the eye of a hurricane of related risks and damage, with family members, friends and peers often suffering as much or more than the user.

Connecticut appears, unfortunately, to be fully in the mainstream of the nation's problem.

When high school seniors were polled recently about whether they had used alcohol in the previous month, 69 percent nationwide responded that they had. The responses in one Connecticut city and two suburban towns all were within a percentage point of 67 percent.

Many of today's heavily-involved drug-use teens got their start midway through elementary school, and 5 percent of Connecticut's 8th-graders say they have tried cocaine.

The effect that this behavior has on students' lives, education and futures is critical.

Last year, in this city, four Connecticut teenagers from a shoreline town went out for an evening and never came home. Tests showed that all had alcohol in their systems when they and their car plunged into a river.

Alcohol also has been tied in as a factor in the growing incidence of suicide and attempted suicides among young people. And with the substantial number of teenagers today who bear children, we must be especially concerned about the effect of substances in the bloodstream of young mothers-to-be.

This hearing is intended to give me and my colleagues on this Subcommittee, who will receive copies of the testimony, a clear view of both the extent of the problem and how well programs address it.

We will be spending some time on each of the three major phases of demand-based—as it is called—programming: education; prevention; and treatment. We will hear from providers and the recipients of these programs.

Before we get started, I would like to thank our witnesses who are here with us today.

I am looking forward to coming away from today's hearing with a better appreciation and understanding of the problem and how we are all doing in trying to deal with it.

Let me share with you very quickly some statistics that I think will be—you will find interesting. And I will lay this out very quickly for you just to share some numbers with you.

And I hesitate to share numbers with you because they can make the eyes glaze over, but I would like to just give you some idea of the depth of the problem and the breadth of the problem.

In 1983—and this is mostly on alcohol, just to give you some idea—in 1983, 28,000 deaths were attributed to cirrhosis of the liver; as many as 95 percent of those cases, according to physicians, were alcohol-related.

In 1983, 17,000 alcohol-related traffic fatalities were reported, and that number has been going up every year.

Between 1975 and 1984, alcohol-impaired railroad accidents resulted in 37 deaths.

Studies in California, Maryland, North Carolina, reported 75 to 80 percent of boating accidents and deaths were related to alcohol; 35 to 38 percent of these fatalities were fatalities where the victims were legally drunk.

In a study done in Canada, 93 percent of male drowning victims were under the influence of alcohol when they drowned; 58 percent of male burn accidents had been drinking at the time of their injury; 60 percent of the 313 emergency room patients who had suffered accidental falls had been drinking.

Now, let me just give you some surveys nationally of 10th-grade students.

Tenth-grade students who have used alcohol in the last month: 53 percent; have been drunk in the past month: 38 percent; have

used marijuana in the past month: 15 percent; have tried suicide: 14 percent.

Connecticut data, suburban towns: used alcohol in the last month: 66 percent; have been drunk in the last two months: 36 percent; have used marijuana in the past month: 18 percent; currently using cocaine: 10 percent; seriously considered or attempted suicide: 13 percent. In other communities, the numbers are basically the same.

Statistics from towns in Connecticut that have done surveys of high school students show the following: driving after drinking or using drugs: 36 percent; drink six or more drinks a week, roughly 16 percent; tried cocaine: 24 percent.

It is also important to note the following Connecticut information. Twenty-six percent of 8th-grade students have reported drinking five or more drinks on occasion; 5 percent of 8th-grade students report using cocaine. The average age—listen to this—the average age of an addicted teenager began experimenting with drugs in grade three in this country.

So you get some sense of the depth of these problems. Again, with 35 percent of suicides, the victim had been drinking; 45 percent of the accidents in Connecticut are related to alcohol abuse. That will give you some idea of how these problems affect human lives.

There is a monetary effect as well. It costs us, in terms of treatment and the loss of property and so forth, almost $90 billion a year, and that is just with alcohol.

There is a tendency—you talk about substance abuse, and there is a tendency to focus just on drugs but, frankly, alcohol abuse can be as big a problem; a larger problem, in fact, in most instances.

So, this morning, I would like to proceed and get underway.

[The prepared statement of Senator Dodd follows:]

PREPARED STATEMENT OF SENATOR DODD

Senator DODD. Welcome to the Subcommittee on Children, Family, Drugs and Alcoholism's Connecticut field hearing on adolescent substance abuse. It is a particular pleasure to be in New Haven this Monday morning, joined by students of Wilbur Cross High School. I hope that one of the first benefits of our work today will be a sense among these students that their government cares about this issue and about helping them lead more enjoyable, productive lives.

In 1987, I assumed the chairmanship of this Subcommittee of the Labor and Human Resources Committee. Our work has been devoted to helping create policy that respects and bolsters the place of the family in the United States today. In this role, I am the author of the Act for Better Child Care Services, or ABC, and of the Family and Medical Leave Act to help American workers keep their jobs during times of family need.

In the past three years, I have also been an original cosponsor of the two major pieces of legislation aimed at the problem of substance abuse. The 1986 Drug-Free Schools and Communities Act included one of my provisions, which targets $20 million to demonstrate effective community-based programs. These programs pro-

vide prevention, treatment and rehabilitation for high-risk youth who abuse—or are likely to abuse—alcohol or drugs. These projects are now under way, and we are fortunate to have with us today Don McConnell of the Connecticut Alcohol and Drug Abuse Commission. CADAC is a Connecticut recipient of one of the Act's grants.

The most recent piece of major legislation is last year's Omnibus Drug Act. Sixty percent of the act's funding is dedicated to education and treatment programs, while criminal and civil penalties for illegal use are stiffened.

The fact is that we have a variety of federal programs, as well as state and lcoal programs, aimed at breaking society's addiction to drugs and alcohol. But so far it seems we just can't kick the habit. One reason is that programs which do more than require us to "just say no" still are not available or accessible to the people who most need them.

That is why, as chairman of the Subcommittee on Children, Families, Drugs and Alcoholism, I am here today. I intend to embark on a thorough review—first at the state level, here in Connecticut—of how pervasive the problem is among adolescents, how the programs are working, and what changes are needed.

A few facts:

- Use of drugs and alcohol among children is happening more and more, and earlier and earlier.
- There is a false popular conception that the problem is limited to cities—making it, for many citizens, "somebody else's problem."
- Drug and alcohol abuse are not "single victim" problems; that is, the person who abuses a substance becomes the eye of a hurricane of related risks and damage, with family members and friends peers often suffering as much as or more than the user.

Connecticut appears, unfortunately, to be fully in the mainstream of the nation's problem. When high school seniors were polled recently about whether they had used alcohol in the previous month, 69 percent nationwide responded they had. The responses in one Connecitcut city and two suburban towns all were within a percentage point of 67 percent. Many of today's heavily drug-involved teens got their start midway through elementary school, and 5 percent of Connecticut's 8th graders say they have tried cocaine.

The effect this behavior has on student's lives, education and futures is critical. Last year, in this city, four Connecticut teen-agers from a shoreline town went out for the evening and never came home. Tests showed all had alcohol in their systems when they and their car plunged into a river. Alcohol also has been tied in as a factor in the growing incidence of suicide among young people. And with the substantial number of teenagers today who bear children, we must be especially concerned about the effect of substances in the bloodsteam of young mothers-to-be.

This hearing is intended to give me and my colleagues on the Subcommittee, who will receive copies of testimony, a clear view of both the extent of the problem and how well programs address. We will be spending some time on each of the three major phases of "demand-based" progrmaming: education; prevention; and treat-

ment. We will hear from the providers and the recipients of these programs.

Before we get started, I would like to thank witnesses who are with us today. I am looking forwrd to coming away from today's hearing with a better appreciation and understanding of the problem and how we all are doing in trying to deal with it.

Before I begin with Director McConnell, I know my colleague, Bruce Morrison, is here and has to move on.

STATEMENT OF HON. BRUCE MORRISON, D-3RD DISTRICT, CONNECTICUT, U.S. HOUSE OF REPRESENTATIVES

Mr. MORRISON. Good morning, Chris. I want to thank you for the initiative that this hearing shows on your part and the part of your Subcommittee to bring this investigation of the problem of substance abuse home in two senses: home here to ask the people in the community about the reality of the problem and how we can address it successfully; and home in the sense that you mentioned, to make clear to the people in our communities around Connecticut that these are problems that are cared about in a serious way in Washington, and we are groping for solutions.

I just want to make a few quick points that are certainly important to me.

You are focusing in this hearing on the issue of demand, the demand for drugs, the demand for alcohol. It does seem to be especially in the control-of-drugs area. And it is very much time that we set priorities as to where we are going to put our number one emphasis. And the reduction of demand for illegal substances has got to be on the top of the list.

Too often in our debates on Capitol Hill, we try to please every constituency by spreading the money around from eradication of drug-growing in South America to interdiction, to various levels of law enforcement, down to the reduction of demand on local levels.

And, so far, there is not enough money being put into the process to solve the problem at any level. And, in my opinion, a very serious investment at demand reduction will have an impact all the way up the chain.

The fact is that there is a lot of money in the drug trade, and that money comes from those who are willing and able to buy drugs.

And if that money is taken out of the system, we can see some real changes all the way up the chain, and then some of our other strategies will have some more effect.

You are focusing here on something that is critically important, and that is treatment and education and other prevention programs. And that is a critical part of demand reduction.

It is, in fact, a tragedy that is common in this community and all across the state that there are people who are addicted to illegal substances—cocaine and heroin in particular—who wish to break the habit, but cannot get the help that they need.

There are waiting lists of 6 months, 12 months, depending on the program.

It is an absolute scandal that we are preaching "say no" but not giving people the tools that they need to say no. And that just has

to change if we are going to take ourselves at all seriously in that regard.

This is a problem that is especially acute for women and especially for women with children; there really are essentially no programs available to those individuals that will allow them to go into a residential setting and still be able to care for their children.

And if there is one thing that might come out of your hearing here, I think it is a focus in particular about helping women in that circumstance because helping women with children does more than just help one individual but helps to rebuild a whole family in a very direct way.

There is something else that I would like to mention that I think is important. At the same time as we beef up our prevention and treatment effort, we must consider the way in which we need to use law enforcement with respect to demand reduction.

We are inclined to talk about law enforcement in forms of let us get the king pins, let us get the people who are the most guilty in a moral sense because they are the people who are making the most profit from the drug trade.

But, frankly, I think that prevention and treatment, demand reduction, means both a carrot and a stick.

The fact is that individuals will not always come to grips with their addictive problems and ask for treatment, but they have to be shown there are very real choices involved. And often times for young people those choices are not clear because there is a lot of money in this drug trade and there is a lot of apparent good life to be had to be involved in it in one way or another.

So I believe that we need to start to make the buying of drugs as serious an offense as selling drugs and that we have to be willing to make our criminal justice system able to accommodate that; in other words, spend the money that is needed in that area so that when we have a sting, as we have many stings here in New Haven and people are arrested, it is a serious consequence for the people who are arrested.

I do not suggest that we send those people away to Somers or to Danbury, but I think we have to have some form of work program, some form of punitive treatment so that those individuals are, in fact, treated as offenders within the system and understand that they have a choice: they can be diverted to treatment if they have a problem and, if they refuse to accept that fact, that their conduct is very detrimental to the communities in which this goes on, they, in fact, are criminals.

That is the choice that people are going to have to make. And I think if that choice is there and we are willing to make treatment available on demand, we might actually get real demand reduction.

In New Haven, I can tell you—as I am sure you hear from our joint constituents—on the streets of many of our neighborhoods, the drug trade has taken over.

And it is, in fact, a frightening statement about our ability to maintain a civilized society that the drug trade is running wild there.

We have to really understand this to be perhaps our number one national security problem; that in most of our cities, people are not safe. And people who, once upon a time, were questioning whether

or not they wanted police to come down their streets are now asking for the National Guard to be brought down our streets.

That is the level at which people are afraid and feel that they are not secure. So it is on the level of a crisis.

I think our emphasis needs to be on demand; it needs to be on treatment and prevention to the greatest extent possible. But I think we also need to have the stick of understanding that buying drugs is as serious as selling drugs because if there were no buyers, there would be no sellers.

[Applause.]

Thank you very much.

Senator DODD. I am now going to ask our first two panelists to join us here at the table. Don McConnell is the Director of the Connecticut Alcohol and Drug Abuse Commission, and Dr. Amy Wheaton is the Commissioner of the Connecticut Department of Children and Health Services.

We will hear from both Mr. McConnell and Dr. Wheaton, and then we will ask them some questions.

STATEMENT OF HON. DONALD MC CONNELL, DIRECTOR, CONNECTICUT ALCOHOL AND DRUG ABUSE COMMISSION

Mr. MCCONNELL. Good morning, everybody. I want to thank Senator Dodd for inviting me here today. I do have a few things to say and a few things to leave with him, a few presents from Connecticut to take back to Washington, which is usually what we do in state government to help people out in the bureaucracy.

But we do have some things here, Senator, that I think you and your staff will find interesting in Washington, speaking about Connecticut.

First of all, we have the secondary school estimates for the calendar year 1987 survey that we took which I think you will find very interesting.

We have some facts about alcohol—some of which you just mentioned—that may be somewhat redundant, but we are going to put those in for the record.

We have a directory of substance abuse services for adolescents in Connecticut for your staff's information.

We also put together an update on cocaine use in the United States. And, as the Senator said, we are looking at younger kids, especially with crack cocaine. And I do not think I am telling any of you anything about crack cocaine, its availability and the harm that it is causing to a lot of families.

The facts about teenage drunk driving are interesting. It is a fact of the matter that the leading cause of death of teenagers in the United States between the ages of 16 and 20 is fatality on the highway, 50 percent and more due to intoxicated driving.

We also started a clearinghouse for drug and alcohol information in the state, Senator. We put 350,000 into this, and I want to give you some information about the Connecticut Clearinghouse on Alcohol and Drug Information. I think it is unique in the country, and we are very proud of it.

And we have also plugged into Infoline in the state, and several calls, in their annual report, come in on either alcohol, for alcohol information, or drug information; 8,500 calls.

We have had 14,000 requests already since November for information from our clearinghouse.

We also have a study here on drugs and alcohol, a study of use and attitudes in Connecticut's state universities, central, eastern, southern and western. So we go up the ladder and up the scale of age.

And then a big problem in our society is the criminal justice system, whether it be the courts, defense attorneys, prosecutors, judges, probation officers, corrections and parole. We have a drug and alcohol abuse crisis within the criminal justice system.

This study just came out March 1st, 1989, Senator, and we will leave that for your perusal.

I know you will be hearing from John Higgins-Biddle later, but I think one of the best studies done in recent years here in Connecticut and around the country is the combined effort with United Way, ourselves and other people, the Youth Substance Abuse Problem in Eastern Fairfield County, which also proves what the Senator just said; that the problem is not an urban problem.

In that area, it is not just Bridgeport, but it is in wealthy suburbs around the cities.

And, as you know, here in New Haven, 50 percent of the drug buys, cars driving in here to the public housing projects and whatever, the cesspools of gang wars, drug trade and so forth—right now, 50 percent of the people coming in are from the suburbs. And the police chief can tell you that.

We also have a study, "Building for the Future," with information and an appendix from our Commission. It is a three-year policy plan.

Then, Senator, finally, I will wave this around later on; it is a transition issue in Washington of the Public Health Service. And I think somebody should take a look at that. I know you have interest in combining NIDA and Triple-A, and I think that is kind of being done under RYSAP as they move into not only primary prevention but secondary and tertiary.

But it is an interesting look at some of the changes going on within the bureaucracy under Secretary Sullivan.

Those are some of the things that I will leave with you, and I would like to make a few remarks if I still have the time.

I want to talk about the pervasiveness of the problem, and I do not want to hook one age bracket with this problem.

The Senator has already indicated—and we know from our experience—that we are dealing with a substance abuse problem that goes from the cradle to the grave.

We are dealing with prenatal care. We are dealing with mothers who are on substances that addict their children in the womb, and we have to give them some healthy baby/healthy mother care.

We are dealing with children who are born addicted to heroin, to cocaine, to alcohol or to methadone and who actually go through withdrawal in hospitals.

We are dealing with young children who have 8,000 hours of television education before they enter elementary school. And you

know what is coming across the television, the boob tube: the pain and the pleasure principle. "If you are in pain, you pop a pill, kid." This is extra-strength this, extra-strength that. And if you want to have fun and you want to look sexy, you drink. And if you love Spuds McKenzie, then you want to be a party animal like him.

And we are bombarded in our brains. "What are you having when you're having more than one?"

You go into the third grade, start a jingle and the kids will finish it for you: "What time is it now after you finish work if it isn't Miller Time?"

But, you know, they never show you what happens after Miller Time, when the macho men who come down from the scaffolds with their hard hats go crawling up their front steps and beat up their wives and their kids. And the kids are embarrassed to invite anybody over to their house because Dad is there laying on the couch and he is plowed.

And, yet, the drug pushers who we talk about are the cocaine kids on the street, using young runners and so forth when, actually, drug pushing is done right before our eyes over the various medias, pushing nonprescription drugs and the legal drug of abuse, alcohol.

I wonder sometimes whether we should not have a law to take this advertising off TV and to save our young kids from it.

And, as you grow up, you are influenced by peer pressure. You go through these schools, and you don't have to go too far if you want to buy a joint, if you want to get a vial, if you want to get a jumbo, even; you've got it. And where do you get the money?

People ask where these kids who are 8 and 9 years old get the money to buy drugs. And you know better than I know that you don't need money; when you are 8 or 9 years old, the candy man gives it to you. And then they hook you in and suck you in little by little, and then you are part of the culture. So we watch the adolescents go down.

I don't think it is the crisis that some people like to talk about. I don't think we are losing an entire generation of people in this nation.

You know better than I, but I see good kids out there. I see kids that are trying. I see student assistance programs in our schools, Students Against Drunk Driving. I see kids taking the reins in their own hands and doing something about it.

And "just say no" seems so simplistic. It is how you say no and how you hold your head up and how you feel about yourself. And all of this has to happen in the school.

I have never met a drug addict or an alcoholic in my 25 years in this area who had a positive self image; every one of them has a negative self image.

And our schools have to do something about inculcating positive self image, as our homes also do.

As we move up the ladder, we see the big problem with substance abuse in our treatment arena. It is between young adults, 22 years of age to 35. Most of the drunk-driving arrests are there.

A few years ago, before this awareness arose, Senator, we had less than 3,000 drunk-driving arrests in Connecticut. Over the past four years, we have had over 16,000 arrests per year.

So, our police are doing a job on the highway, but we still realize that we are only getting about one in one thousand. So our highways are really not too safe.

And all we are detecting is alcohol because we do not have any roadside tests for drugs.

And as we go up into the brackets, we are now dealing with a second generation of drug abusers. Those who were in the colleges in the sixties are now parents who have teenagers and above.

They are drug-wise. Some of them are still fooling around with drugs. But there is no doubt in our minds that, if you put away the criminal justice sector and look at the health sector, the two biggest drugs of abuse are legal: nicotine and alcohol.

And if you look at the American Medical Association's statistics, 1,000 Americans die per day as a result of smoking; 350 die per day as a result of alcohol and alcohol-related diseases; cirrhosis of the liver, chronic pancreatitis, gastritis, coronary problems and brain problems. And two die a day as a result of cocaine. Heroin and marijuana do not even compute in the health statistics for morbidity and mortality. However, if you look at the other system with which we deal—not the health system, but the criminal justice system—the guns on the street are ample. There is a run on guns in California today because the legislature might take automatic weapons out of the sales bracket.

So we look at what is happening on the street, with the many, many people who are dying, most of them being shot one way or another because of the drug trade.

And then we have the treatment system which is inadequate throughout the country.

A few years ago, we had no treatment system. But in the last 10 years, we have an ample treatment system; yet, it is inadequate.

In Connecticut, we have about one million people affected by substance abuse out of 3.2 million. Three hundred and fifty thousand are addicted to alcohol or drugs, and they affect approximately four other people in their lives. That is the affect, the influence.

We treated last year, Senator, 43,000 people in alcohol treatment centers, 22,000 in drug treatment centers.

Seventy-one percent of our inmates of the 10,000 inmates we now have in Connecticut are there because of drug-related crimes. Most of them are poor and addicted people and need treatment.

Forty-five-point-two percent of the homicides in Connecticut are drug-related. Forty-four-point-six percent of the suicides are drug-related.

And I could go on and on, but time is pressing and I want to get off. But before I do—and when I get on a roll here, Senator, you know how bad I can be.

But, anyway, in our treatment system, we do have today for this problem 1554 beds, 2,000 methadone slots, 2,800 drug-free outpatient slots and 168 long-term beds for the very chronically-impaired alcoholics.

Senator DODD. Let me ask you this. How long does the average person have to wait in this state, if they want to get off drugs today and they say, "Look, I'm addicted. I want to get off."?

If you are in New Haven, how long do you have to wait before you get into a treatment program?

Mr. MCCONNELL. We have 575 people on the waiting list right now. If you are in New Haven in particular, you probably—if you are on heroin—have to wait about three months.

Senator DODD. What is the likelihood that a person who wants to get off of a drug can wait three months?

Mr. MCCONNELL. Nobody is going to wait—if he is a drug addict and wants what he wants and wants it now, he is not going to wait.

Senator DODD. How do we compare nationally with those averages?

Mr. MCCONNELL. I think we are better than some of the national averages. In New York, it's completely out of control and so is California.

But in Connecticut, we are doing okay.

Senator DODD. Is that true for adolescents?

Mr. MCCONNELL. In adolescents, we need more beds for adolescent treatment. But there is a waiting period for adolescents.

And I would like to say something there, Senator. If you have money, you can get treatment; insurance will cover you, and there is treatment not only in Connecticut but other places in the United States that your child can go to.

Senator DODD. I want to thank the students. I know you have another class to go to. We appreciate your coming by.

We will take a couple of minutes break so that the people can change classes.

Now that the change of classes has been completed, the Subcommittee on Children, Family, Drugs and Alcoholism will come to order.

I want to welcome these students who have arrived and just quickly tell you that this is a Subcommittee hearing, a formal Subcommittee hearing of the United States Senate of the Subcommittee which I chair in the Senate of the United States dealing with children and families, drugs and alcoholism.

And today, we are talking to people from the state agencies and commissions, as well as parents and other people involved in these programs at the local level and state level on how well the programs in our state work, particularly with younger people.

We have just heard from Don McConnell, who is the Director of the Connecticut Commission on Alcohol and Drug Abuse. He has been talking about some of the statistics and the problems that they face particularly with younger people.

And I want to thank Don for his testimony.

We are now going to hear from Dr. Amy Wheaton, who is the head of the Connecticut Youth Services Program, Commissioner of the Connecticut Department of Children and Youth Services, who will talk about particularly what happens with younger people.

And then we will be hearing from others in the state, plus parents, as well, on how well or how poorly things are working in Connecticut.

So, Dr. Wheaton, we thank you for being here.

STATEMENT OF HON. DR. AMY B. WHEATON, COMMISSIONER, CONNECTICUT DEPARTMENT OF CHILDREN AND YOUTH SERVICES

Dr. WHEATON. Thank you very much, Senator. A number of statistics have been presented, and I will not belabor the statistics.

However, it is noteworthy that the current statistics on substance abuse are silent on one profound and alarming matter: the abuse of children.

In Connecticut, we estimate that about 65 percent of our referrals on seriously abused children involves parental substance abuse.

Statistics sometimes fail us because they are, after all, just numbers.

Let me give you three examples of the impact of substance abuse when used by an adult who is a parent.

Lisa was beaten, molested and abandoned; she is four years old; her mother uses drugs.

Tasha was sexually abused and, as a result, she has a venereal disease. She is five. Her mother uses drugs.

Chris and his siblings were beaten. Chris suffered a blood clot on the brain. The x-rays showed old fractures in his ribs and legs. The prognosis is poor. He is twelve. The father was drunk. His mother has used cocaine.

I will turn now to a discussion of adolescents, and I find it helpful to deal with real stories. I am going to tell you the story of a real tough kid. I am going to tell you that I have met lots of kids, but I have never met a bad kid. I have met lots of kids who don't yet believe in themselves, but I have never met a bad kid.

And I will tell you the story of a real tough kid who was scared and intimidated and frightened people. His mother came up from the south; her mother had died when she was eight and her father a few years later.

When she came to Connecticut to stay with her sister, at age 15, she gave birth to a real tough kid. A year later, she had another child. She was a single parent.

Our real tough kid lived in the project with his mother; she had a variety of relationships. There were allegations of prostitution and arrests and convictions for abuse of marijuana and cocaine.

She was evicted often and moved from place to place and town to town.

A lot of the time, our real tough kid was on the street in war zones while his mother entertained. Her kids were humiliated.

At seven, our real tough kid had tantrums at school; at eight, he was fighting at school and occasionally brought knives. At age 10, he brought marijuana to school. At all, he was sexually abused. He started hearing voices.

He is 15 now and in a correctional facility, having been arrested for theft from a person trying to sell him marijuana.

He is trying to find his way, working hard to be a different person, a better person. And sometimes, he is afraid.

He wrote a letter: "Please give this to my momma when I am gone. Dear Momma: I love you very much, and I always had in the back of my mind to buy you a big house. I have been through a lot

and so have you. I have done some wrong things in my young life. When I am gone, please go on and make it in life. I just cannot cope with the peer pressure and so on, people messing with me. I ain't worth a thing anyway. Earthly life is hell to me, the things you go through. I cannot control my anger that much. I love you and miss you and, when I am gone, I will always remember that I love you more than anything. I cannot even help myself, Momma, so I cannot help you.

"People laugh at me in their minds. I am praying for death, but remember, Momma, that I will always, always love you."

In addressing the needs of our young people, our adolescents, I think we need to be mindful of a couple of things. Two members of the legislature, two members of the judiciary and eight kids in protective agencies in Connecticut have spent two years studying our social service system.

And, as you know, the public is fond of talking about the fragmentation and the lack of coordination among human services. But I want to tell you we have discovered two root causes.

I will give you one simple example of the problem facing us as we try to develop services that are responsive and effective and efficient in meeting the substance abuse needs of our kids.

An adult is abusing alcohol or drugs and, for whatever reason, they undergo an evaluation. Inpatient substance abuse treatment is recommended. Fortunately, there is a program and a bed; perhaps even the person is rehabilitated.

Is this a success story? Unfortunately, no. The adult happens to be a single parent mother with no extended family. So her three young children are taken into protective custody while she is in treatment.

She loses her AFDC and her housing. Upon discharge, her children cannot be returned to her until she has a place to live. She cannot get an apartment without AFDC. She cannot obtain AFDC because her children do not live with her.

This is a system based on categorical funding.

A second problem, I think, in developing programs to deal with substance abuse among young people is that we act as if we know absolutely nothing about the development of children and adolescents or the developmental age.

None of us can go out and build a house without regard to the people who are going to live in it and where it is going to be built. We do that over and over again. We focus on one particular problem of one particular family member and fail to focus on the child in the context of the family, their school, their friends, their neighborhood.

I would like to suggest a model scheme, Senator, with an approach of collaboration as opposed to categorical and which also addresses the needs of children as we know it today; that is, our understanding of child and adolescent development.

The first is the community youth service system that works with adolescents, parents, schools, businesses, civic clubs, churches, elected officials, to create opportunities for young children to experience success, to earn approval and become contributing members to their family, their school, their community.

What a youngster needs most is to believe in themselves because they have experienced some success which warrants them believing in themselves.

In Connecticut, we call these organizations "youth service bureaus." There are 70 of them in the state; they are grossly underfunded.

The second prevention program: a community-based family support center where parents gather together to talk with one another about the trials and tribulations of being a parent and, yes, its chores, where they can learn about positive parenting and parents as teachers, child and adolescent development; whatever it is they need to know to become competent, nurturing, supportive parents.

In Connecticut, we fund 11 such centers very modestly. As to the communication management system, this works with children and youth at serious risk by working with the entire family of the unit.

What typically happens when you address substance abuse among youth is that you tell the kid he has a problem, so you remove him from the home. And that confirms his conviction that he is the one with the problem, not his family. It also confirms the family's conviction that the kid is the one with the problem, not them.

I will speak later of moral treatment programs because they involve the family.

What I am saying now is that too much of our federal and state dollars are being expended after a crisis occurs, when often the damage is irreparable and un-healable on all sides.

The community case management system then works with the family not in a therapeutic sense but an instructional sense.

I have never sat on the floor of an apartment with a family when that family could not tell me what the problems were and, furthermore, which one brought them or caused them the most trouble that caused any one or all of them to abuse one of them, alcohol or substances.

And then the communication manager connects them to the services to help them.

As to treatment in the home, there are models nationally. Some are very good in California: The child does not come to the office of the professional for the treatment. The professional goes to the home of the child, and the treatment involves the child and the family.

Finally, there is inpatient treatment, intensive 45- to 90-day treatment. I would like to see such treatment require as a condition of admission the involvement and participation of the family or significant other of that youngster.

We find there are very few such programs in Connecticut now.

Let me say that, today, there are more people over the age of 65 in this country than there are adolescents. Connecticut ranks as the second oldest state in the country where the median age of state population is compared.

The significance of this is noteworthy: Our children are our most valuable resource; they are our future.

I salute you, Senator Dodd, for your leadership in addressing the needs of children and youth.

Senator DODD. Thank you, Dr. Wheaton, very much.

Senator DODD. Brian Lynch is the Chief Executive Officer of the Children's Center in Hamden, Connecticut.

Brian, we welcome you here this morning. I will say to you publicly—all of your statements are made a part of the record.

If you want to just paraphrase them in your own words without reading every word, do not worry about them not being included in full in the record; they will be in there.

And I would ask you to keep them brief if you can so that we can get to some questions. We will get through everyone, and then I will open this up a little bit. We are going to do something a little unique; we are going to have parents asking questions, as well as me, of some of the people involved. So this is not going to be a normal senate hearing.

Things are normally just done with senators asking all the questions, but I am going to invite you as panelists to engage with one another as well.

Brian.

STATEMENT OF BRIAN LYNCH, CISW, CHIEF EXECUTIVE OFFICER, THE CHILDREN'S CENTER, WAKEMAN HALL ADOLESCENT SUBSTANCE ABUSE PROGRAM, HAMDEN, CT

Mr. LYNCH. Thank you, Senator Dodd. The Children's Center is a multiservice agency which has been providing services to children for over 150 years.

Every day, we have more than 125 children on our campus in our residential, day and school programs.

Four years ago, we began our adolescent substance abuse program—Wakeman Hall—one of the first programs of its kind in Connecticut. In addition, a satellite facility opened last year in the Town of Branford.

In our brief history, Wakeman Hall has seen more than 1100 children in need of treatment for substance abuse, and over 600 have been admitted to our program.

I would like to address some of the needs we see as providers of adolescent treatment services.

First is the availability of illicit substances. At The Children's Center, we have seen adolescents from communities in all areas of our state; suburban, urban, and rural.

Primarily, the adolescents we see are using cocaine, alcohol and marijuana. There is no community where alcohol and other drugs are not widely available to young people.

Many of the young people entering treatment report the onset of substance abuse prior to age 13.

We need community awareness programs for adults which will explore our attitudes toward substance use and the responsibilities of parents, teachers, and others in providing positive role models for young people.

Community awareness programs which will identify the high risk behaviors and factors also need to be begun.

We need prevention programs for each school district, programs which are appropriate to each community, realizing that "just say no" is not relevant if crack is being sold on your corner.

We need programs which specifically address the needs of children at high risk, such as; a child growing up in a family where there is a history of substance abuse is two to four times more likely to become addicted.

We need prevention programs with a family-centered approach which will address the needs of that entire family and where the system can possibly intervene and possibly help the family deal with their substance abuse issues, also helping them to stay together and prevent another generation of addiction.

Two, the school/community-based early intervention programs: Adolescents report an average history of substance abuse for more than two years prior to entering treatment.

We need programs in schools and local communities which will identify and provide community-based services for adolescents who are binge-users or in the early stages of regular use. These programs need to include the entire family.

We need to provide substance abuse training for professionals who come in contact with these young people and their families—physicians, teachers, coaches, counselors—so that they can identify substance abuse problems and effectively intervene.

Three, treatment services: For those adolescents who are unable to remain drug-free, we need a continuum of treatment modalities; outpatient services, day treatment services, residential and hospital-based options.

No single treatment modality works for all substance abusers, and we need to offer services which will meet the needs of each individual.

Treatment needs to be accessible to all families. Substance abuse has been called this nation's number one medical problem; yet, insurance coverage is not always available.

In Connecticut, there are no mandates to provide for primary drug abuse treatment other than alcohol, and no provisions for reimbursement of outpatient care.

Even with the mandate for 45 days of residential care, some medical insurance carriers and HMO's will only provide coverage for 30 days or less of residential care.

This leaves the burden of treatment cost to the family or the state, and treatment stays are being determined by insurance benefits, rather than individual needs.

We need specialized programs to meet the complex needs of adolescent substance abusers with other problems. These include: the dual diagnosis adolescent with a substance abuse problem and a psychiatric disorder; the pregnant adolescent and young parent who are drug-dependent; the adolescent substance abuser who is also learning-disabled; the adolescent who has been physically and/or sexually abused and is now chemically dependent; the adolescent addict who is self-mutilating or exhibits suicidal tendencies—and 40 percent of adolescent suicides involve alcohol or drugs; the adolescent who does not have a healthy family to return to and requires long-term residential care.

Aftercare services: There is a tremendous need and a lack of services available for adolescents returning to the community.

With the decrease in residential days available, solid aftercare treatment becomes more critical.

We expect adolescents to return to the peers that they were using drugs with after only a few weeks of sobriety achieved in the controlled environment of a treatment facility.

We expect them to return to their schools and communities which are not prepared to assist them with their transition and new sobriety.

Many of them are unable to maintain their sobriety in the face of these challenges. School personnel need to be better trained so that they can address the needs of their students when they return to school.

School-based group counseling and self-help—AA and NA meetings—also need to be developed so that the school environment promotes recovery and healthy lifestyles.

Young people outside of school need more positive opportunities and, again, the family needs support from community institutions to continue the recovery process.

We desperately need facilities for adolescents who are unable to return home.

Halfway houses are needed for those that need more structure that often cannot be maintained in the community.

Residential group homes where adolescents can interact with the community and learn some independent living skills within a supportive environment are also needed.

Finally, we support the concept of regional partnerships and planning to address the individual, family and community needs created by substance abuse.

Regional planning, such as the RYSAP model, which we will hear about later, has brought together community leaders to develop a comprehensive plan which benefits all the communities involved.

In conclusion, the war on drugs is not being fought only at the borders of the United States, but on the streets and in the schools of our communities.

As in any war, our children become the victims: children who are living with addicted parents or family members; children who are addicted themselves and are in jail or dying because of their own personal struggle with this disease; children who cannot go outside because of the shootings in the neighborhood, such as the five-year-old boy in New Haven last week who was being driven to school by his father. While driving, his father was shot and killed in what appeared to be another drug-related execution.

As a society, we have a responsibility to protect our children and to provide a safe environment for them in which to live and grow.

Thank you very much.

[Applause.]

Senator DODD. Thank you very much.

[The prepared statement of Mr. Lynch follows:]

PREPARED STATEMENT BY BRIAN F. LYNCH

Good Morning. My name is Brian Lynch. I am the Chief Executive Officer at The Children's Center in Hamden, Connecticut. The Children's Center is a multi-service agency which has been providing services to children and families for over 150 years. Every day, we have more than 125 children on our campus in residential, day treatment, and school programs. Four years ago, we began our adolescent substance abuse program, Wakeman Hall - the first program of its kind in Connecticut. A satellite facility opened last year in Branford. In our brief history, Wakeman Hall has seen more than 1100 children in need of treatment for substance abuse and over 600 have been admitted to our program.

I would like to address some of the needs we see as a provider of adolescent treatment services.

1) Availability of Illicit Substances

At The Children's Center we have seen adolescents from communities in all areas of our state; suburban, urban, and rural. Primarily, the adolescents we see are using cocaine, alcohol and marijuana. There is no community where alcohol and other drugs are not widely available to young people. Many of the young people entering treatment report the onset of substance use prior to the age of 12. In a weekly reader survey 40% of the sixth graders responding to the survey felt peer pressure to use alcohol and/or drugs.

We need community awareness programs for adults which will explore our attitudes towards substance use and the responsibilities of parents, teachers, and others in providing

positive role models for young people. Community awareness programs which will identify the high risk behaviors and factors are also needed. We need prevention programs for each school district, programs which are appropriate to each community, realizing that "just say no" is not relevant if crack is being sold on your corner. We need programs which specifically address the needs of children at high risk, such as; a child growing up in a family where there is a history of substance abuse is two to four times more likely to become addicted. We need prevention programs with a family centered approach, which will address the needs of that entire family and can intervene to do everything possible to help the family deal with their substance abuse issues, stay together, and prevent another generation of addiction.

2) School/Community Based Early Intervention Programs

Adolescents report an average history of substance abuse for more than two years prior to entering treatment.

We need programs in schools and local communities which can identify and provide community based services for adolescents who are binge users or in the early stages of regular use. These programs need to include the entire family. We need to provide substance abuse training for professionals who come in contact with these young people and their families (physicians, teachers, coaches, counselors, etc) so that they can identify substance abuse problems and effectively intervene.

3. Treatment Services

For those adolescents who are unable to remain drug free, we need a continuum of treatment modalities - outpatient services, day treatment, residential, and hospital based options. No single treatment modality works for all substance abusers and we need to offer services which will meet the needs of each individual. Treatment needs to be accessible to all families. Substance abuse has been called this nation's number one medical problem, yet insurance coverage is not always available. In Connecticut, there are no mandates to provide for primary drug abuse treatment other than alcohol, and no provisions for reimbursement of outpatient care. Even with the mandate for 45 days of residential care, some medical insurance carriers and HMO's will only provide coverage for 30 days or less of residential care. This leaves the burden of treatment cost to the family or the state and treatment stays are being determined by insurance benefits, rather than individual needs.

We need specialized programs to meet the complex needs of adolescent substance abusers with other problems.

1) The dual diagnosis adolescent with a substance abuse problem and psychiatric disorder.

2) The pregnant adolescent and young parent who are drug dependent.

3) The adolescent substance abuser who is also learning disabled.

4) The adolescent who has been physically and/or sexually abused and is now chemically dependent.

5) The adolescent addict who is self mutilating or exhibits suicidal tendencies - and 40% of adolescent suicides involve alcohol and other drugs.

6) The adolescent who does not have a healthy family to return to and requires long term residential care.

4. Aftercare Services

There is a tremendous need and a lack of services available for adolescents returning to the community. With the decrease in residential days available, solid aftercare treatment becomes more critical. We expect adolescents to return to the peers that they were using drugs with after only a few weeks of sobriety achieved in the controlled environment of a treatment facility. We expect them to return to their schools and communities which are not prepared to assist them with their transition and new sobriety. Many of them are unable to maintain their sobriety in the face of these challenges. School personnel need to be better trained so that they can address the needs of their students when they return to school. School based group counseling and self help (alcoholics anonymous and narcotics anonymous) meetings also need to be developed so that the school environment promotes recovery and healthy lifestyles. Young people outside of school need more positive opportunities, and again, the family needs support from community institutions to continue the recovery process.

We desperately need facilities for adolescents who are unable to return home. Halfway houses are needed for those that need more structure than is available in the community.

Residential group homes where adolescents can interact with the community and learn some independent living skills within a supportive environment are also needed.

Finally, we support the concept of regional partnerships and planning to address the individual, family and community needs created by substance abuse. Regional planning, such as the RYSAP model, has brought together community leaders to develop a comprehensive plan, which benefits all of the communities involved.

The war on drugs is not being fought at the borders of the United States, but on the streets and in the schools of our communities. As in any war, our children become the victims. Children who are living with addicted parents or family members; children who are addicted themselves and are in jail or dying because of their own personal struggle with this disease; children who can't go outside because of the shootings in the neighborhood; and the five year old boy in New Haven last week who was being driven to school by his father. While driving, his father was shot and killed in what appeared to be another drug related execution.

As a society we have a responsibility to protect our children and to provide a safe world for them.

Thank You.

Senator DODD. The next witness is Louise Bernier of Clinton, Connecticut.

And let me tell all of you in the audience how particularly pleased I am that Mrs. Bernier and other parents who are here this morning have attended.

Some of the people are people who work every day in the business of trying to improve treatment and education programs and interdiction and the like, but for parents to come out and to talk is not an easy thing to do.

And I want all of you here in the audience to know how much I appreciate, as the chairman of this Subcommittee and senator from this state, the fact that we have constituents in our state who are willing to come to a public forum and talk about what otherwise would be an intimate family issue.

So I am particularly honored. I know all of us in this audience, Mrs. Bernier, and others are very pleased that you have come out today to talk about these issues.

It helps if you share the experiences like this. So we thank you for being with us. We will be glad to receive your testimony.

STATEMENT OF LOUISE BERNIER, CLINTON, CT

Mrs. BERNIER. I wish to testify this morning on four points; one is the lack of availability of treatment centers.

When we were first told that our son was in a crisis and that we should get him into inpatient treatment without delay, the first problem we faced was obtaining guidance and information.

We discovered there were very few resources which could provide any information.

Once identified, we found that most treatment centers catering to adolescents were at such a distance—New Hampshire, New York—that we would not be able to be involved in his treatment as a family.

Family involvement was very important to us.

Second, insurance reimbursement is inadequate. Our insurance only covered a portion of his stay and is limited to once in a lifetime.

Our involvement in support groups has led us to believe that addiction in adolescents is not taken seriously by insurance carriers. Our insurance coverage ceiling is far below what is needed for recovery.

Our out-of-pocket monthly payments are in the high hundreds. Sooner or later, all of society is going to have to pay the price. More effort should be put into prevention and treatment.

Three, aftercare programs are extremely important. After his 45-day inpatient program, our son returned to high school. It became evident that it was impossible for him to function in an atmosphere that did not understand drug addiction. He soon dropped out of school.

My involvement with parents' support organizations indicates that those who are not involved in aftercare programs have a limited success rate.

My husband and I are in deep fear for his future. How will he support himself without so much as a high school education?

Four, lack of counselors with training in substance is a problem. When we started looking for a counselor for our son after his inpatient treatment, we soon discovered few counselors had an understanding of drug addiction, fewer still were willing to work with adolescents.

Some told me that they were experienced and did work with substance abusers, but it was evident, after asking a few questions, that they knew very little. We found that there is little help for the confused, addicted adolescent.

Frustration in our search for a qualified treatment center and follow-up counseling, lack of insurance coverage continuance, all the time our son crying out for help, has led to much stress in our family. This has been an emotionally as well as financially draining year.

Thank you.

[Applause.]

Senator DODD. Thank you very much for that testimony.

[The prepared outline of Mrs. Bernier's statement follows:]

PREPARED OUTLINE OF LOUISE BERNIER STATEMENT

I. Introduction

A. Family background
B. Can only speak for ourselves

II. Beginning

A. Experimented at about sixth or seventh grade
B. Our first reaction was probably denial, to do other would reflect on us
C. Gave every indication of being a normal young adolescent
D. "Episodes" kept getting progressively worse at about 13 years old
E. Got help from family doctor, then therapist

III. Realization of the Problem

A. For me later than my wife
B. Sister knew all along, kept dropping hints, paid no attention to her
C. Went for help again, this time for drugs
D. Problem could not be ignored
E. Things were out of control

IV. Effect on Family

A. Took control of the house
B. Thought of him as a "five hundred pound gorilla"
C. Almost total breakdown of family unit
D. Love turned to hate, causing guilt on our part

V. How We Got to This Point

A. Minor trouble with the law
B. Able to get him to The Children's Center with help from Brian Lynch and court

VI. Where We Are Now

A. Forty-five day inpatient care, aftercare, work with therapist, at his request for him
B. Family working also with therapist
C. Parents Support Group (for myself, the single most helpful) (Detail)

VII. Accepting Our Responsibility For Contributing to the Problem

A. Our generations naive attitude about drugs (Detail)
Movies, TV, even Judge Ginsburg was part of it

VIII. Prevention

A. Education: Home, school
B. Increase funding for programs like The Children's Center and many others
C. Expand private health care coverage
D. Hold President Bush to his word

IX. End

A. Advice from my grandfather

Senator DODD. Dr. John Higgins-Biddle is the Director of the Regional Youth Substance Abuse Project in Bridgeport, Connecticut.

We thank you for being with us this morning, and we would be glad to receive your testimony.

STATEMENT OF JOHN HIGGINS-BIDDLE, DIRECTOR, REGIONAL YOUTH SUBSTANCE ABUSE PROJECT, NIDA GRANT RECIPIENT, BRIDGEPORT, CT

Dr. HIGGINS-BIDDLE. Thank you, Senator. I will try to shorten my remarks.

I am delighted to be offered the opportunity to talk with you. It has been maybe two years since Ms. Goodspeed and Betty Frame and I briefed you on what we were doing in the Greater Bridgeport Region, and a few others.

I think we have made a lot of progress and, Senator, I will not go into all the details of what we are and all of what we have done.

But I would like to point out just a few things that I think might add somewhat to the valuable messages that you have been hearing already this morning.

You will recall that our organization is seeking to establish a complete continuum of services in the Greater Bridgeport Region, including community awareness, prevention, intervention, treatment and aftercare.

But it is critical to understand that we provide no direct service whatsoever. We are simply a coordinating mechanism and instrument for change, and change primarily of two sorts: change in people's individual attitudes and behavior in regard to this problem and, also, change in all the institutions through which our society collectively relates to young people.

That, I might add, is no small task, but that is the task that the leadership of the Greater Bridgeport Community has taken on to focus on the demand side of this issue.

We started that four years ago when you were about the only person in Washington who was focusing on the demand side. We are still there, and I am glad that you are still there as well.

Your staff asked that I talk about some of the successes that we have had——

Senator DODD. And some of the failures, too.

Dr. HIGGINS-BIDDLE. I will get on to that, too. Let me focus on one part of the work that we have been concentrating on for the last year-and-a-half.

We have trained now over 400 school personnel to serve on student assistance teams that serve, in part, to identify at the earliest possible age young people who are drug-and alcohol-involved.

We now have these teams in every junior and senior high school in the region, public and parochial schools. And that effort has involved over 8,500 person hours of training to the schools—that is, time away from school classes and other responsibilities—and uncounted hours of substitutes.

Veronica Skerker, I am sure, will give you a lot more information about the efforts that the schools have to undertake in order to make a difference in this area.

We have two full-time people working on my staff with our local school systems in the State of Connecticut, and the State Department of Education has one; she is terrific, but we need more of them.

These school teams have begun to identify kids with problems. But now the question is how can those kids get the help they need, the very question that was just raised to you.

We have developed over the past year-and-a-half what apparently is a new model of service in Connecticut and perhaps in the nation to answer this problem.

You have detailed information about it through your staff, but let me cite a few of its characteristics.

First, it provides independent, standardized and objective assessment and diagnosis of the problem; not only the drug and alcohol aspect of the problem, but with sensitivity to the other kinds of social and maybe medical problems that are attendant in the child and also in the family.

In addition, this service prepares a treatment plan for the child and for the family. It refers them to the available and affordable services in our region and in our state, and it provides a case management function to see that the treatment plan is completed or modified and then completed.

We have received over $1 million to support this program for a two-year pilot period from the nation's largest health care philanthropy, the Robert Wood Johnson Foundation, and funds that come from the State of Connecticut and are at the discretion of Governor O'Neill; these are coming through Dr. Wheaton's Department of Children and Youth Services.

The program includes a research component that Dr. Babor will mention more about to you, but I think it is important to understand that this program is a strategic intervention in our meager array of treatment services for youth in Connecticut.

It is designed to have a number of important consequences. It provides a gatekeeper function, channelling up to 500 kids this year and up to 750 next year, that we believe will result in a cost containment system by the prescription of the most cost effective form of treatment appropriate for a particular diagnosis and by negotiating charges with treatment providers.

It will also result in an increase in the supply of treatment services by natural market forces when treatment providers see that money is to be made by providing treatment services whether by outpatient, inpatient, or some new combination models that we hope will be developed for a significant number of kids in our community.

It will also monitor the quality and encourage the development of new services and more effective models of treatment.

And in these functions, this service will not be allowed to provide treatment unless the service, itself, will be assured a degree of neutrality because it is responsible to a very broad-based community organization which, collectively, I think, has the best interest of the kids and the society at heart.

We believe that our organization can accomplish these ends better than if such accountability is left solely to the insurance companies or solely to the treatment providers alone.

20-137 0 - 89 - 3

You should know that our model of early intervention and treatment is being considered by Congressman Pete Stark of California by replication under some legislation he is now preparing.

And should that legislation proceed and get across to the senate, we would very much appreciate your support. And perhaps you could team up in advance and sponsor some legislation on both sides of congress.

I mentioned that I would point out some shortcomings. I think probably the major one is that we simply have not convinced enough people of the need to concentrate on the demand side of the issue, to understand that the causes of this problem lie close to the very nature of how society sets its values. And that connection of the problem will require a veritable revolution in our society that will take years and will take tremendous effort on the part of all of us.

I do not believe, personally, that we or certainly our government through its elected officials can ever win a war on drugs because it is very clear that the enemy in that war is the American people themselves.

And I think we had better start examining our own activities as a society.

We export $4 billion of narcotic tobacco that is grown with government subsidies. What is it that we are trying to do in our society to change ourselves? Maybe we ought to stop talking about wars and begin developing a new social contract between the people of our society and the government because the people ultimately have the responsibility.

I would mention a number of other failures that we have had to date, but let me focus on two more.

We need to create programs for drug-involved kids that meet their whole needs.

As Dr. Wheaton was talking about the needs of the family, so, too, we need to have programs that not only provide drug and alcohol treatment but will address in some fashion the need of kids to have values and meaning in their lives; that usually comes through education and through work. Thus, we need to combine drug treatment with education for dropouts and also pre-employment skills and job training and job placement and support networks all together in the same programs, not to chase kids or anybody in our society to six different offices around town in order to get the combination of services they need.

Finally, we must develop better and more equitable ways to assure that everybody in our society, especially our kids, have access to quality treatment for their diseases.

In this regard, we launched last week a research program to develop recommendations for the improvement of public payment for the youth substance treatment especially through medicaid.

Chemical dependency is a disease. We already have a national insurance plan for the poor to deal with this disease, but it is so poorly designed that virtually no kid in our largest city in Connecticut, where 39 percent are eligible for medicaid, ever get any medicaid-funded treatment for their drug problems. That is a disgrace.

We are beginning to work on it, but we will need your help in congress, and then we will need to seek other improvements in the private insurance plans.

And I would add, finally, that in both cases the main problem is that we do not allow less expensive treatment for substance abuse; we require more expensive treatment, and that is simply not available because the insurance bases, both public and private, do not pay the cost of the more expensive, yet you are not allowed to seek less expensive treatment.

I used to work here in New Haven, and it is nice to be back in what was for a long time my home town. I taught History at Yale University, and I studied—for longer than I care to remember—social and political and religious revolutions in the history of western civilization.

Teaching our society in regard to this issue is going to require a revolution, and revolutions only happen when there are people who have a vision to see a better future and when those people can coalesce that power to effect that vision.

We need to forge that vision and we need to share our power, and we will continue our work through our partnership of hundreds of local people and our state officials in the Greater Bridgeport Region, but we cannot do that job alone.

We need and we are counting on your help in Washington, and we offer you our full commitment to assist you in any way we can.

[Applause.]

Senator DODD. Thank you very much for your statement. I think 30 percent of all the states in this country have a mandated insurance benefit of assistance from the treatment plan but Connecticut, unfortunately, is not one of those states that falls into that category.

And I know, as I look down the lines here, that you will be arguing for that.

I would just make another observation, and I have made this before. Normally, I do high schools forums around the state on Mondays, and this is a subject that has come up over and over again.

In fact, I think some of the students here may have attended a couple of the forums we have had. And there is a subject that all I have to do is raise it, and you could spend the entire two hours in these discussions with young people on the subject.

One of the things that has come out of every high school forum I have held—I have asked the young people which messages work the best—"just say no" or the athletes on television right now with the NCAA Final Four National Championships, with a lot of athletes out talking about the harms of alcohol and drug abuse.

And one of the messages was and the young people said that it is all negative, there is very little positive; it is "just say no" or all these things will happen. It is true.

But there is not a sense of "say yes to life." I mean, there are positive things that we have not been doing. And I wonder if our message is so negative that it is depressing in terms of what the alternatives are in the positive sense.

And I really am just raising that with all of you here as we move on down the line.

But that has been one message that the people have been talking about here, some of whom are sitting in front of us here today have said to me, at any rate: the messages are all negative; "You are not telling us about what life ought to be like. It is just what life is going to be like if you proceed down the path of substance abuse."

I think it is an important message; that may be what we are missing in the drafting of some of these particular proposals.

And the last thing I would say before moving on here is there is one emotion that gets politicians, elected officials, nervous, and that is an angry constituency. When your constituents get mad about something, they have a tendency to write and call; they rarely call you when they are happy about something; when they get angry, they will let you know.

And until the affected constituencies of this state and the 49 others get really angry about what is not happening, frankly, we will be nibbling around the edges of this stuff.

And you get your revolution—I agree—when people have a vision of the future, but you also get it in democracies when people insist that their tax dollars be spent on things that are important to them.

And, frankly, until we get that kind of anger being expressed by parents and young people across this country about what is not happening or what is going on in their communities, things will not be much different.

Since I just heard the bell, I gather we are going to lose some more people.

[Recess.]

Senator DODD. Dr. Thomas Babor is a professor of Psychology at the University of Connecticut, a nationally recognized expert on alcoholism.

And we are very honored and pleased that he could take time to be with us this morning.

Doctor, we are going to receive your testimony.

STATEMENT OF THOMAS F. BABOR, PROFESSOR OF PSYCHOLOGY, DEPARTMENT OF PSYCHIATRY, ASSOCIATE SCIENTIFIC DIRECTOR, ALCOHOL RESEARCH CENTER, UNIVERSITY OF CONNECTICUT HEALTH CENTER, FARMINGTON, CT

Dr. BABOR. Thank you. I am very pleased to be here, too.

What I would like to do is to start off by introducing some concepts that may be worthwhile if you are thinking about treatment services for adolescents.

I would like to summarize some general findings that have emerged from the research literature over the past 10 or 15 years, and this will set the stage for some recommendations that I will propose for the Federal Government's involvement in the planning of treatment services.

First of all, we have found that, while there may be a genetic basis for alcohol and drug dependence, there is an equally prominent influence, if not dominant influence, of environmental factors. And that is important because we do have the ability to modify the environment. And we should not give up just because we think

that for some individuals this is a disease that is inevitable. We could be doing a lot more in terms of changing the environment.

Second, although dependence on most substances does not typically develop until adulthood, we know the precursors of dependence, the problems of dependence and much else that can be recognized clearly start in adolescence.

So, we should be focusing on the adolescent period if we are going to deal with this problem.

Third, most adolescent substance use and the problems associated with it tend to remit without the need for formal treatment when adolescents move into adult roles and responsibilities.

That is important because the main problems that adolescents experience—suicide, depression, accidents, violence, family conflict—all of these things are associated with substance abuse and not necessarily with the clinical syndromes that tend to manifest themselves later on.

We can think about this in terms of two problems. One is the problems associated with acute intoxication; the other is the later problem that eventually develops into addiction and dependence. They are not the same thing, and they should be approached differently.

Fourth, regular use of psychoactive substances, such as marijuana, alcohol and cocaine, at the developmentally critical life periods of late childhood and early adolescence does, indeed, interfere profoundly with normal growth and development.

And it is important then to target our programs at high-risk youths who are in those phases of development.

Next, initiation to substance use during late childhood and early adolescence follows a predictable course. And the predictable course starts with legal substances such as tobacco, beer and wine; that proceeds to hard liquor and marijuana experimentation and then, only later on, gets into hard drugs, which tends to dominate our attention.

One conclusion from this is that we should focus on gateway drugs such as alcohol, tobacco and marijuana.

And, as Director McConnell mentioned, most of the deaths that we are going to be dealing with in the future are going to be from tobacco. And tobacco, at the same time, is the introduction to smoking marijuana.

We should focus on these drugs and not have our attention completely dominated by the more lurid details of cocaine and heroin use, which only affect a small minority.

Six, substance abuse eventually develops into alcoholism, and addiction tends to be associated with a cluster of familial and psychological risk factors.

Some of these things are very interesting to pay attention to: risk factors such as parental alcohol and drug use, a chaotic family environment, shyness, aggressiveness, learning disabilities, conduct problems.

We know that these factors are associated with the early onset and more rapid development into eventual dependence. And I think we have the tools now to identify those who are at high risk of serious problems and those who are at less of a risk of serious

problems who, nevertheless, need a less intensive form of intervention.

Finally, the prevalence of alcohol and drug abuse in our society is strongly influenced by those economic and social conditions that affect children and adolescents.

These conditions include the widespread availability to adolescents of discretionary income, a period of rapid social change when norms are not consistent, significant amounts of unstructured leisure time and role models that include deviance. These things could be a focus of prevention programs.

These generalizations, supported by a growing body of research that has been sponsored mostly by the Federal Government, suggest that treatment policy should be formulated with a clear understanding of the nature and dimensions of the problem.

In the absence of a strong federal presence in the treatment of adolescent substance abuse, there has been a rapid growth in services, albeit inadequate at present, but a rapid growth of services and programs that, for the most part, are unstandardized and unevaluated.

There is now an important need to focus our attention on programs that work and concentrate the resources that we have in areas that will not squander the limited resources that we have.

So what can we do? Well, one thing we can do is pay attention to some of the success stories that have recently become apparent; for example, the combination of treating and referring and taking a stiffer approach to drunk-driving has led to a significant decline in accidents and deaths associated with drunk-driving.

Similarly, there have been dramatic reductions in the number of adult smokers, particularly male adult smokers in our society; they have the function of information dissemination, availability of free intervention programs, doctors paying more attention to the health effects of smoking, and in changing public attitudes.

Thirdly, there has been the example of the military where drug screening and other measures, including treatment, have produced what appears to be a dramatic decline in the prevalence of substance use among military personnel.

These are examples which would not be apparent to us unless there were some evaluation, most of it supported by the Federal Government.

And the federal agencies that are responsible for this, the National Institute on Alcohol Abuse and Alcoholism and the National Drug Abuse Institute, both deserve continued federal support in their efforts.

Another thing the Federal Government could be doing is to strengthen its efforts in the area of treatment policy implementation.

During the 1970's, NIAAA was instrumental almost by itself in stimulating the development of a multifaceted network of treatment services, employee assistance programs and reimbursement mechanisms that have evolved into a broad continuum of treatment options for the adult population.

That kind of initiative, I think, could be brought to bear on the adolescent treatment population and the need for services among adolescents.

At present, treatment services are chaotic, unstructured, haphazard, have poor reimbursement support, and are rapidly developing to the point where we do not know what is going on.

I think the Federal Government could be doing a number of things, some of which were suggested by Dr. Wheaton, to set up model programs, demonstration programs, and insist on the proper evaluation of these programs.

Third, there is an important need for federal leadership in the determination of how scarce resources should be allocated for prevention and treatment services.

There tends to be a sharp division between prevention and treatment services. You call RYSAP and you have a suggestion for something in between. And you say, "It is not prevention and it is not treatment." You cannot find funding for it.

I think there needs to be recognition of the two major thrusts that we recommend, prevention and treatment; they tend to be complementary.

And there is something in between which is called "secondary prevention", which is focusing on high-risk youth.

Pure prevention, particularly shotgun approaches that are focusing on a population of youth starting at low grades, while well-intentioned, has not produced persuasive evidence that it is effective in the long run.

And while this should not be discouraged, I think we need to look at the amount of resources that are being put into efforts like broad-based education approaches as opposed to those that seem to work for high-risk populations, such as peer approaches and alternative approaches.

These kinds of things should be considered, and there is federal leadership that could be directed in focusing our efforts.

One example of the broad-based community approach that is dealing with high-risk youth is the Youth Evaluation Service Project, the YES Project that John Higgins-Biddle alluded to, within the general RYSAP initiative.

And this project, I think, could be seen as a demonstration, an example that could serve as a model, because it involves developing diagnostic and assessment procedures that will help us to differentiate potential alcoholics and drug addicts from those who will mature out of their problems but, nevertheless, need less intensive programming. It is going to help us to determine which types of adolescents are most appropriate for inpatient versus outpatient and community-based programs that may not traditionally be considered treatment.

It is going to help us to monitor client progress over time. It is going to produce reports that will tell us how the program is working.

And I am very happy to see that somebody like John, who has been focusing on developing a program, has spent equal effort in getting his programs evaluated. It is not something that is easy.

When he came to me and asked if the University of Connecticut would be interested in this, I said, "Yes, but there is no money available either from the RYSAP side or the Federal Government side."

We had to work with John for about six months voluntarily before we could get funding from private sources. And the state now is involved in supporting a statewide survey which will provide us with additional information about this project.

So we are putting together the resources, but the resources were not easy to put together to evaluate this program.

And I think what the Federal Government should be doing is supporting demonstrations, supporting evaluation, disseminating information from these projects and then thinking about structural changes such as changes in reimbursement policies that will help to facilitate the implementation of these programs.

Finally, I would recommend that your committee pay careful attention to two studies that are currently being conducted by the Institute of Medicine which were mandated and requested by the congress.

One study, which has been ongoing for about a year and a half, has been focusing on alcohol treatment services. And part of that study, "A Report on Services for Adolescents", a second companion study, is dealing with the treatment of drug abuse and drug dependence.

Both of these reports will probably be out in the summertime, and I think they will contain recommendations that are consistent with what I have been talking about and which will help the Federal Government to come up with a more creative approach for the kinds of things that need to be going on at the local level. Thank you.

[The prepared statement of Dr. Babor follows:]

PREPARED STATEMENT OF THOMAS F. BABOR

Senator Dodd and Members of the Subcommittee:

Let me begin by expressing my gratitude for the opportunity to testify at this hearing. The issue of adolescent substance abuse is one that concerns me greatly as a parent, a psychologist, and a researcher.

What I would like to do today is to speak about some recent developments in the treatment of adolescents with substance abuse problems. These developments include the steady proliferation of new services, new ideas about the complementarity between prevention and treatment, and a better understanding of the underlying causes of alcohol and drug problems. I am happy to say that some of these developments have originated here in Connecticut where epidemiological studies, clinical research and innovative treatment policy are being coordinated in a unique demonstration program that is funded by state and private sources. I will finish with some modest recommendations about the role the federal government can play in these efforts.

Let me begin with some general statements about adolescent substance abuse, based on recent scientific evidence:

1) While there may well be a genetic basis for the development of alcohol and drug dependence, there is strong evidence for an equal, if not dominent, role of environmental factors. Substance abuse is in large part a set of learned behaviors and attitudes that for most adolescents is strongly influenced by the surrounding environment. Much of the learning and control of these behaviors takes place within the peer group and family settings.

2) Although dependence on most substances does not typically develop until adulthood, most of the precursors to addiction are established in late adolescence.

3) Most adolescent substance use, and the problems associated with it, tend to remit without the need for treatment when adolescents move into adult roles and responsibilities. While the problems experienced, such as accidents, violence, interpersonal conflict, and depression, tend to be significant from a public health perspective, it is important to note that not all substance abuse should be conceptualized as if it represented a unitary disease or disorder.

4) Regular use of psychoactive substances such as marihuana, alcohol, and cocaine at the developmentally critical life periods of late childhood and early adolescence can interfere profoundly with normal growth and psychological development, and tends to put severe

strain on family functioning. Infrequent use of psychoactive substances, however reprehensible from legal and moral points of view, does not constitute a major risk to adolescent development, beyond the problems associated with acute intoxication.

5) Initiation to substance use during late childhood and early adolesence follows a predicable course, beginning with legal substances like tobacco and alcohol, proceeding to less addictive illegal substances like marihuana, and eventually evolving, for a small minority of the adolescent population, into regular use of more addictive substances like cocaine and heroin. While it is these latter substances that attract much of the public's concern, the use of alcohol, tobacco and marihuana by a large segment of the adolescent population is a significant public health problem because of the effects of these substances on accidents, injuries and psychological functioning.

6) Substance abuse that eventually developes into alcoholism and addiction tends to be associated with a cluster of familial and psychological risk factors that include parental alcohol and drug use, a chaotic family environment, shyness, aggressivness, learning disabilities and conduct problems. Adolescents without these risk factors are more likely to avoid substance use, or mature out of substance abuse as they become older.

7) The pravalence of alcohol and drug abuse in our society is strongly influenced by those economic and social conditions that affect children and adolescents. These conditions include the widespread availability to adolescents of discretionary income, a significant amount of unstructured leisure time, and role models who approve of deviance. Substance abuse problems historically have followed a cyclical pattern of rise and decline across generations. We may be entering a period when substance use has begun to decline.

These generalizations, supported by a growing body of research that has been sponsored mostly by the federal government, suggest that treatment policy should be formulated with a clear understanding of the nature and dimensions of the problem. In the absence of a strong federal presence in the treatment of adolescent substance abuse problems, there has been a rapid development of services that for the most part have been unstandardized and unevaluated. These services range from expensive hospital-based psychiatric facilities that sequester adolescents for periods up to six months (provided that they have insurance coverage) to innovative mutual-help and recreational programs that are supported by voluntary contributions. While the development of a range of services in many respects is laudable, it is unfortunate that there are no clearly specified criteria for determining which services are suitable for the different populations of substance abusers described above.

A proper federal response to the need for treatment services for adolescents with substance use problems should include the following elements:

First, it is important for the federal government to carefully monitor trends in substance abuse over time. This is best done by means of epidemiological surveys of the school age population, a procedure that has aided planning efforts immeasurably. While we cannot expect to find any one treatment or prevention measure that alone reduces the incidence and prevalence of substance use, we may be able to learn when our efforts are contributing to the decline that inevitably takes place when society decides that substance abuse can no longer be tolerated. The examples of significant reductions in drunk driving and cigarette smoking provide encouragement to those who believe that public policy and public education can make a difference. In addition to the national surveys that have been sponsored by the federal institutes (NIAAA and NIDA), I am pleased to report that the Connecticut Alcohol and Drug Abuse Commission (CADAC) will be conducting a statewide school survey in approximately six weeks. This survey has been designed to provide planning data that will assist with the development of adolescent treatment services.

Second, the federal government can strengthen its efforts in the areas of research, prevention and treatment policy. During the 1970's the National Institute on Alcohol Abuse and Alcoholism was instrumental in stimulating the development of a multifacited network of treatment services, Employee Assistance Programs, and reimbursement mechanisms that have evolved into a broad continuum of treatment options for the adult population. A similar national effort could be initiated for the adolescent population, where there is now a great need for a similar initiative. While there has been little attention until recently to the treatment of adolescent substance abuse, fedearl agencies such as NIAAA, the National Institute on Drug Abuse, and the Office of Substance Abuse Prevention, are capable of initiating research and demonstration projects in this area. Funding should be provided for this purpose.

Third, there is an important need for federal leadership in determination of how scarce resources should be allocated for prevention and treatment efforts. While there is a general perception that more is better, at present there is a significant risk that our scarce prevention and treatment resources are being squandered. For example, it is generally assumed that the most effective way to deal with alcohol and drug abuse among children and teenagers is to educate everyone of them before substance use begins. Unfortunately, the outcomes of such efforts over the past decade have been equivocol and generally unimpressive, especially

when directed at the broad, heterogeneous population of children. Our efforts might better be directed at the more specific population of high risk youth who would benefit most from early identification and brief interventions that border between prevention and treatment. These programs would be directed at heavy users of alcohol and marihuana as well as those who have begun to experiment with more addictive substances. An example of such a program is a demonstration project that is currently being intitiated in the Greater Bridgeport area. Called the Youth Evaluation Services Project, this program is designed to: 1) conduct systematic diagnostic evaluations on adolescents who have been indentified as having a present or potental problem with psychoactive substances; 2) develop an individualized intervention plan based on the nature and severity of the problem; 3) refer the client to an appropriate community program or treatment provider; 4) monitor the client's progress for a period of up to 18 months. This kind of program is designed to prevent the inappropriate use of scarce resources while matching adolescent substance abusers to the best available services.

Finally, it is important to note that the Congress has recently commissioned two major policy studies of treatment services, one dealing with alcoholism treatment and the other focusing on treatment of drug abuse problems. Both studies are being conducted by the Institute of Medicine, a division of the National Academy of Sciences. Because these studies will be presenting the Congress with major policy recommendations about the efficacy of treatment and the best way to finance it, I would recommend that the Senate Subcommittee review these reports as soon as they are published, which could be as soon as this summer.

Senator DODD. Our next speaker is Veronica Skerker. First of all, if you want to talk about some of the Herculean tasks, how would you like to be responsible for guiding the substance abuse curriculum of the state's 165 school districts, helping them with their intervention programs?

You are pretty much a one-person band. We welcome you here this morning and are anxious to hear how you are doing and how one person can be expected to really do that.

STATEMENT OF VERONICA M. SKERKER, DEPARTMENT OF EDUCATION, HARTFORD, CT

Ms. SKERKER. My opening comment, Senator Dodd, is that two years before I came to the state, I was young and gorgeous, and this is what the state has done to me in two years.

[Laughter.]

Ms. SKERKER. I personally would like to thank you for your Community Act Fund; without the money that that fund has brought to us, I would have absolutely no money and the school districts in Connecticut would have absolutely no money to do programming.

And I think that, as we look back over the years at that funding, we will see that in Connecticut, particularly, it has made the difference. And I personally would like to thank you.

I also would like to tell you that I sometimes curse you at 4:00 o'clock in the morning grant reports, but that is another story.

I have given you my formal testimony, and I do not want to reiterate that because that is knowledge-based.

What I would like to do with you is share with you some of my emotions. As you suggested, I am the one-person show with the state's Department of Education in charge of sex, drugs, AIDS, suicide, health, et cetera. And I have filled that job for two years, so I have a lot of impressions.

I have virtually been to every school system in the state. In the last six months, I personally have trained over a thousand teachers for more than 21 hours. So I have had a lot of experience.

What I would like to share with you is some of the feelings I have had. I am actually very depressed with what I find out there and also very often frightened.

As I thought of what I could tell you today, I thought of the old Indian proverb about walking a mile in my moccasins. So I would like to invite you to walk a mile in my shoes for the next five or so minutes.

I would like you to be impressed, as I often am, going to very poor schools and meeting teachers who have no money, no resources, who have had to close the top floor of the building because the roof leaks and, yet, are doing marvelous things for children.

And they become very frustrated when they have a child say, "I need help," and they have no place to send that child because there is no public place for that child to get treatment, or very few, if any. I would like you to feel the frustration these very caring, loving teachers feel.

I would like you to be sad with me as I was recently where a teacher called me and said that, in a school system in suburban Connecticut, the kids were so discouraged that they were writing

letters to their teachers asking them to come to their streets to really find out what the drug problem was like.

There was only one teacher who showed up. And that one teacher listened to the children of the school talk about drugs and allowed them to come after school the next day.

And in this classroom, there were 81 children who were asking and begging the adults of this world to pay attention to them.

I have to also say that, in the same school system, they have no drug problem in that town.

I would like you to feel the frustration that I feel as I talk to administrator after administrator who tells me there is no time to teach about drug education, that they cannot find 15 minutes a week to teach because it is too difficult to find that time and it is much more important to improve SAT scores.

I would like you to feel the anger I feel when administrators say things to me like the following: "We will not accept Drug-Free Schools money because it would be perceived that we have a drug problem in our town, and our property values will go down."

I would like you to hear about the administrator who says to me, "Drugs are dirty business. We do not want to get our hands dirty, so we will not teach drugs."

I want you to feel the anger I feel and the frustration I feel in trying to get leaders in our school systems to pay attention to the issue of drugs.

I would like you to be excited with me about programs like John's Regional Youth Substance Abuse Program that is trying to link communities and break the denial that some of us here deal with.

I would like you to feel the fury I feel when the administrators in the towns say their music programs and AP programs are much more important in schools.

And my comment often is, "I have yet to meet a child who died because he could not play the flute." Yet, we still put our time and energy into those kinds of programs.

I would like you to do the training with me and hold the teachers who end up in my arms crying because of a child who really did come from an alcoholic family; and one of the reasons they could not teach drugs to kids is that they had to process their own pain.

I am the only employee in the state who is in charge, as I pointed out, of all the programs dealing with the kids and the problems we are talking about.

We have no state funds coming to me next year. I will have to train 32,000 teachers and 500,000 children on no state dollars. So without the Drug-Free Schools money, I have nothing.

Just to give you a little comparison, in Massachusetts, the person who has my job has 80 people working under her on state payroll and a budget of $30 million coming from the state.

The State of Maine, which is considered to be a poor state, has 26 state workers just to deal with drug and alcohol issues.

We, in Connecticut, the richest state in the union, have one.

Lastly, I would like to share with you a perception that I have.

I do not know if you have been to Disneyland, but I finally got to go down there this past fall. And after being there for three or four days, I decided I wanted to live in Disneyland.

In Disneyland, there were clearly no bums on the street, flowers did not die, the lawns grew very green. Clearly, there was no jumping out of the windows of the palace. And, as I often comment, Mickey and Minnie have been married for 50 years and, yet, they have no children; so, clearly, there is no sex in Disneyland. And I decided to stay there because it was a lovely place.

And then I came back to Connecticut, and I found that the reality is that the adults in Connecticut want to live in Disneyland, too.

As I go from place to place and talk to hundreds of adults all over, they live in Disneyland. But, in the real world, the kids in Connecticut are not living in Disneyland. This is a state where we had 9,000 kids pregnant last year, 4,000 kids with venereal disease, 1 out of 7 girls attempting suicide, 1 out of 10 boys attempting suicide, 90 percent of all high school seniors sexually active without available information or birth control, and, clearly, 90 percent of our kids using alcohol on a regular basis and seeing that as not being a problem for them.

We truly have two Connecticuts: the Connecticut of the adult world that is very pretty and lovely to look at; and, unfortunately, the world in which are kids are living. And I think our children are asking us desperately to help them, but I do not think there are too many adults who are listening. I guess all of us here today have to listen to Robert Frost's words that often keep me going late at night, and that is, "We have miles to go before we sleep and miles to go before we sleep."

Thank you very much.

[Applause.]

[The prepared statement of Ms. M. Skerker follows:]

PREPARED STATEMENT OF VERONICA M. SKERKER

In order to eliminate drug abuse within the State of Connecticut and throughout the United States, effective programs must be implemented that address the continuum that includes prevention, intervention, treatment and after care. These components should include the following:

- o Prevention Education including age-appropriate, developmentally-based curriculum that integrates knowledge and skills for all students in grades K-12, parent education and community education;

- o Intervention Strategies including clear, precise and equable drug policies and procedures, identification of students "at risk" or exhibiting warning signs of inappropriate behavior and referral procedures of student for "in-house" as well as community based services;

- o Treatment Services including "in-house" and residential treatment for drug abusing youth; and

- o After Care Services for youth and parents, after drug treatment has been completed.

Presently, in Connecticut, to the best of my knowledge, there are NO schools that are, in fact, providing the above mentioned services. To date, intensive on-site visits have been made of 35 school districts. NONE of these schools have in place a comprehensive drug prevention program for students in grades K-12 in spite of Connecticut General Statute 10-19(a), which mandates drug education for every student every year and has done so SINCE 1969 and the Federal Drug-Free Schools and Communities Act of 1986.

With the knowledge, that there are no school districts that have attempted to eradicate drug abuse through systematic prevention education and intervention, the following Connecticut statistics are not surprising:

- o Of the 8th grade students surveyed, 26% reported drinking 5 or more drinks on ONE OCCASION;

- o Of the 8th grade students surveyed, 5% reported using cocaine;

- o The average age an addicted teenager began "experimenting" with drugs was between 10-12;

- In a study done in a suburban town, 43% of the seniors reported trying marijuana between the ages of 11 and 12;

- In another study done in a suburban town over 80% of the seniors reported spending $20 or more a week on alcohol, 40% spent $20 or more a week on marijuana and 20% spent $20 or more a week on cocaine; and

- 13% of Connecticut youth have attempted suicide.

Faced with these and other statistics, why have Connecticut schools failed to implement comprehensive drug abuse prevention programs? The answer is NOT simple. Often I hear educators say the following:

- The drug problem is so big, we are just wasting our time and resources.

- There are only so many hours in the day.

- In order to teach everything, the State mandates, we would need to increase the school day! ...School year!

- Drug education is really something parents should teach.

- If children see parents using drugs, what can we do at school to change what kids do?

- By the time the kids get to high school, it's too late!

- Schools were designed to teach reading, writing and arithematic NOT deal with social issues.

- Other schools may have a drug problem, but not my school.

While many of these statements have some element of truth within them, I believe the reasons schools have not implemented effective programs are encompassed in the following points:

- <u>Denial of a problem by a school district</u>

  Connecticut is the richest State in the Union. It contains lovely homes, picture perfect towns and well educated people. Adults do not want to believe that children growing up in big homes, with green lawns, could possibly "do drugs." A safe perception that many adults protect themselves with is "Only poor, inner city kids use drugs."

  Furthermore, once the adults of Connecticut accept the fact that drug abuse is epidemic within their schools and communities, then they most act - action requires time, effort, money and self-evaluation. It truly is simpler to believe, "Not my kid!"

- <u>Priorities of a school district</u>

  In many districts time, energy and resources are directed towards the basics, mathematics and language arts, programs that are perceived to increase student's scores on standardized tests, or popular programs such as instrumental music.

Health and drug education programs are viewed as unnecessary for a particular school district's students, "something" parents should teach or something that can't make a difference for their students. Thus, drug prevention education is rarely a district's top priority.

- Desire for the status quo

Subtle but real, is the desire of school personnel to maintain the statue quo. Introducing comprehensive drug prevention programs requires training staff, purchasing/developing materials and develop strategies and procedures for dealing with students, parents and staff who surface as drug abusers.

- Fear of perceived failure by educators

Acknowledging a drug problem within a school district may be perceived by the community as a result of the failure of the administration to do their job. Thus, many educators would rather not acknowledge the extent of the drug problem within their school or district.

- Frustration with lack of services available

Presently, in Connecticut there are virtually NO treatment beds available for student who lack insurance. Community resources are limited and in some rural areas they do not exist at all. Educators who work hard to identify and refer students for treatment, often quickly become frustrated and angry over the lack of help available for young people and simply give up.

- Lack of trained staff

Connecticut has only 185 certified health educators to teach drug education, a component of health education in over 900 schools.

Many educators have not kept pace with changes in drug abuse education therefore, many educators do not have sufficient information to honestly access the extent of drug problems within their school or to know what programs to implement.

- Acknowledging the "Demons Within"

25% of all school personnel are adult children of alcoholics, UNKNOWN NUMBERS are married to alcoholics, are alcoholics themselves or are siblings, parents or friends of alcoholics or drug addicts. Before someone can effectively teach or implement a drug prevention programs, they must deal with their own feelings, fears and personal myths concerning drug abuse.

- Lack of funding for drug education programs

The only funding available for drug education programs other than from local sources is the funding available through Drug-Free Schools and Communities Act of 1986. Presently, funding level is only $2.50 per student, far below the cost of implementation of effective programs.

Many of these obstacles seem insurmountable. I believe, however, that in order to overcoming these barriers, we must form coalitions and creatively seek solutions that are needed to truly create a drug-free lifestyle for ourselves and our children.

Some suggestions that may serve as a springboard for more creative and comprehensive solutions are as follows:

- o Provide leadership

  Drug including alcohol abuse is unacceptable. This message must be given by words and deeds. As we changed society's view of tobacco use, so we can change society's view and use of other drugs. We as adults MUST set a positive role model.

- o Drug Abuse Prevention must become a priority of schools, communities and society

  Once again, leadership is necessary to break through denial and allow the needs of our young people to dictate the priorities of the adults.

- o Provide funding on both the State and Federal level

  By providing funds, the leaders of our society not only provide necessary funds but also send a clear message that drug education is a priority of our society.

- o Implement State and Federal mandates

  While no one likes to be told what to do, drug education mandates do help educators implement programs that they are reluctant to implement by themselves.

- o Provide adequate community-based treatment facilities

Submitted by : Veronica M. Skerker

State Department Of Education
Consultant in Substance Abuse, Health and Safety

Senator DODD. We have with us Carol Wright, the assistant principal of Weaver High School in Hartford.

While I know you do not have any formal testimony, I did not know if you wanted to share anything with us.

STATEMENT OF CAROL WRIGHT, ASSISTANT PRINCIPAL, WEAVER HIGH SCHOOL, HARTFORD, CT

Ms. WRIGHT. What I would like to say is, first of all, I am from an urban area. We have approximately 1400 students.

And in my short time in trying to gather information for this committee, I did talk to another vice-principal, I talked to two security officers, and I talked to the people who really have the information; my students.

In talking with these various people, it was very amazing to find that there is so much diversion in their opinions as to whether there are drugs in the school: yes, there are; no, there are not.

Some folks can tell you where the drugs are sold. Some students will tell you, no, they are not sold in the school; they are sold outside of the school.

One of the important points that I felt that my students at Weaver High School were concerned about was that, even though we are a minority school, that they wanted me to say that this is a problem that occurs everywhere, that it just does not occur in an urban school.

And I thought that that was very important, that they would want to have their school shown in a positive light.

When I talk to students about what can be done about the problem, a few students tell me they did not think anything could be done simply because the problem is so pervasive.

At that particular point, I really became quite discouraged.

As a vice-principal, I am responsible for approximately 400 youngsters. I do not see drug trade going on. However, I think I am aware that it is in our schools.

I do see an increasing amount of violence going on in our community. That violence has been somehow carried over into our schools; we get the ramifications of it.

But just to say that we have drug busts in our school, that is not a problem.

What really concerns me is that there are drugs in the schools, and why is it that we as adults, we as educators, why is it that we cannot put our finger on it? The students know more than we do. It is such a sophisticated networking system that goes on among them that it is hard to detect.

I have also been involved in the State Department's training program, and we have set up a team at Weaver High School.

There are five people on my team; myself as the administrator; guidance counselor; school nurse; school social worker.

We have a drug and rehabilitation counselor from the community, but she has really her own agenda. A lot of information is confidential that she cannot share with us.

Trying to get it to work in reality is extremely difficult for us. We do not have the real expertise. So we are meeting among our-

selves, trying to come up with a model that is going to work for our students.

How can four administrators or four people in the school system service 1400 students for students that are experiencing a lot of difficulties?

So that is one of the problems that we have. We have approximately eight guidance counselors. Again, our guidance counselors are not truly trained to deal with students who are experiencing some real problems.

So some of the comments that I heard this morning in terms of training and prevention are needed at our school.

And at this point, if some of you want to ask questions about what goes on at our school and how we try to solve some of the problems, I would be glad to answer those questions.

Senator DODD. We will come back to that. We will try and finish up with our witnesses, but I appreciate it very, very much.

And if you have some formal or written testimony, please just send it to us and we will make it part of the record.

[Applause.]

Senator DODD. Our next speaker is Gene Calzetta, from Madison, Connecticut. He is a parent.

And what I said earlier about Mrs. Bernier goes for you as well, Mr. Calzetta. We appreciate your being here with us this morning and telling us about your family situation as well.

STATEMENT OF GENE CALZETTA, MADISON, CT

Mr. CALZETTA. During the break, Senator, when the audiences were changing, I said that the real experts on this are out there; we have the facts and figures, but they live with it every day. And I see some of the student body here just to listen, and this is their future that we are talking about here.

I am from one of those shoreline, affluent communities you were talking about. I am a proud graduate of Wilbur Cross High School, for starters. I was born and brought up in New Haven.

My wife and I—blue collar, Italian family, hard workers—got to move out to the suburbs, with the house, the pool, the whole bit.

We did not expect to ever be sitting in a position like this.

We have two children. My son is the eldest. He seemed to be developing normally, and then, at some point—I guess it was the junior high school years, which seems to be a very pivotal period for young people. They are breaking away maybe from the house and they are finding themselves.

At that point, he started experimenting. Our first experience, I guess, was when he was in about fifth grade—I think it was fifth grade when we came home and found him passed out for about six hours, drunk. He and a friend had been drinking.

But we immediately thought it was nothing more than just experimentation by youth.

Denial seems to be a pervading attitude for parents initially: "It cannot be that my son is an alcoholic or a drug addict because that means I did something wrong." So, we denied it at the beginning.

And the episodes just kept getting progressively worse. We went to our pediatrician who recommended Brian Lynch. Fortunately, we got some help with Brian.

But he just kept getting into worse and worse situations. There were drug deals in the high school. We would get a phone call; the teacher caught him selling drugs. Fortunately, he got away with that; maybe he should not have, but he did.

It progressed. I will not bore you with all the episodes, but I will bring it up to date to about a year ago; what got my son into a program.

I was away in California on a vacation. And my wife works evenings in a restaurant. She was not gone for more than three or four hours.

And from what I could tell, depending on who you ask, there were 100 to 150 people at my house for a party, with beer about an inch thick on the floor.

If you ask my son, there were five people there. If you ask the police, there were 150. So you can figure out exactly what it was.

But I am here to say that this is not an isolated incident. You could float a battleship on the beer that is drunk on the shoreline on a weekend. It is not only beer. There is a progression. It goes from marijuana—well, it ended up with snorting heroin. And that is what we progressed to.

Now, I often say, "Why did it happen to me?" We do not have the drive-by shootings that you have in the city. We do not have the violence or anything. So I wondered why was it happening out here.

The reason is that somewhere there is a bottom line, there is a common denominator somewhere in there. I do not know what it is; I am not the expert.

I do know what our personal experience is. There are no alcoholics on either side of our families, so there is nothing there. It is just a pervasive attitude.

I am a parent. I am 42 years old. I was brought up in the sixties. And we had a very naive attitude toward drugs in that period. And now we are parents, and I do not think all of us take it seriously until our children start doing the drugs. And it is starting to be very visible now.

We had a Supreme Court nominee who was turned down because he smoked marijuana. That is just the tip of the iceberg.

You have a generation growing up now who are—who, in the mid-sixties and early seventies experimented and did not think there were any consequences. Well, now the prices are being paid; they are being paid with our children.

And Dr. Wheaton mentioned that she had never met a bad kid. My son is a good kid, a good boy. And he is working very, very hard, and I am very proud of him.

He is at the Wakeman Hall now. He did his 45 days, he came out. The best judgment was that he should stay there for the aftercare meetings and not go back to his high school.

Again, we are talking about going into an—not talking about an inner city high school; we are talking about an affluent community high school where there should not be any problems. I mean, there is no one there with shotguns at the door.

No offense, but the bathrooms at the high school there are open. I tried to go to the bathroom here. I had to get a janitor to open the door. And this is better than it used to be, and I really feel for these young people.

But, anyway, what I was saying is that my son is working very, very hard at this.

But he went back to the school. And he tried very hard but, after about two weeks, he did not come home one evening. And I do not take that too well, and I was up until about 3:00 or 4:00 in the morning, until I finally went to bed.

The next morning, he called at work and he said to me, "Dad, I have to go to aftercare." And I think that was the point where he took over responsibility. Up to that point, I was responsible. He finally realized he had a problem.

And they are working well with him up there, and he seems to be trying very hard. But there is so much work that has to be done.

You can only do so much as a parent. Like I said, in the sixties, we were all going to change the world. And you find out as you get older that you do not change the world, but you change the corner you are in maybe. And that is all we are trying to do here.

I would like to just give one more personal note. My grandfather who is 94 years old and spry as anything—and my son is very close to him, as I am—told me when my son

was born—or, right after he was born, he said, "Being a parent is like a bow and arrow. You aim your best and, once it is gone, it is gone. You do not get the arrow back."

So I guess what we are trying to do here is maybe aim the arrow a little better, and that is what these young people here should realize.

I sat out there once with that glazed look in my eyes, too. It is not going to be long before they will be parents, and the problems that they are going to face are 10 times worse than the ones we are facing now. And they need help. We are all going to need to get help.

Thank you very much.

[Applause.]

Senator DODD. Thank you very much.

[The prepared outline of Mr. Calzetta statement follows:]

PREPARED OUTLINE OF GENE CALZETTA

I. Introduction

A. Family background
B. Can only speak for ourselves

II. Beginning

A. Experimented at about sixth or seventh grade
B. Our first reaction was probably denial, to do other would reflect on us
C. Gave every indication of being a normal young adolescent
D. "Episodes" kept getting progressively worse at about 13 years old
E. Got help from family doctor, then therapist

III. Realization of the Problem

A. For me later than my wife
B. Sister knew all along, kept dropping hints, paid no attention to her
C. Went for help again, this time for drugs
D. Problem could not be ignored
E. Things were out of control

IV. Effect on Family

A. Took control of the house
B. Thought of him as a "five hundred pound gorilla"
C. Almost total breakdown of family unit
D. Love turned to hate, causing guilt on our part

V. How We Got to This Point

A. Minor trouble with the law
B. Able to get him to The Children's Center with help from Brian Lynch and court

VI. Where We Are Now

A. Forty-five day inpatient care, aftercare, work with therapist, at his request for him
B. Family working also with therapist
C. Parents Support Group (for myself, the single most helpful) (Detail)

VII. Accepting Our Responsibility For Contributing to the Problem

A. Our generations naive attitude about drugs (Detail)
Movies, TV, even Judge Ginsburg was part of it

VIII. Prevention

A. Education: Home, school
B. Increase funding for programs like The Children's Center and many others
C. Expand private health care coverage
D. Hold President Bush to his word

IX. End

A. Advice from my grandfather

Senator DODD. Latricia Gill is a senior at Hall High School in West Hartford, part of a project called Project Concern.

Latricia said to me when I came in, "I am nervous. I am the only student up here."

You do not have to be nervous at all. I want you to relax. And we are grateful that you could make some time to be with us this morning to share your thoughts and views with us.

STATEMENT OF LATRICIA GILL, SENIOR, PROJECT CONCERN, HALL HIGH SCHOOL, WEST HARTFORD, CT

Ms. GILL. Thank you. Sitting here, looking out at you guys, you know, I can really relate to having people speak to you, lecture to you.

And I want to talk to you guys because I am 17, I am a senior. And in a few months, I am going to be going off to college.

I live in two separate worlds. I am a student in Project Concern which means, in the daytime, I am in West Hartford, Connecticut, which is a very affluent suburb and, in the evenings, I am in Hartford, Connecticut in a project where I live.

In my school, like this guy here said, drugs to them is a joke. On the weekends, life for them is parties, beer, sex and drugs. And that is just bottom line.

In Hartford on the weekends, it is the same thing but, at a party, people fight, they shoot each other and kill each other. And there is no need for that. But the bond that is between them and those things happening is drugs.

And I know a lot of you are sitting out there saying, "Well, you know, drugs is this and drugs is that. I am sick and tired of hearing about drugs." But, you guys, we have to do something about it.

Coming down here in the car this morning, we were talking about drugs in Hartford. You know, I mean, sometimes, in Hartford, you cannot even walk down the street because of drugs.

I have a prepared speech here that I was going to read but, I mean, I want to tell you guys what is up. I want to tell you guys what is up out there.

I am looking at the four of you over there, and we are the same. I'm Black. You're Black. And the problem for us is that we are in poverty. Do you know what I mean?

It is, like, life for me is, in the morning, I am in school and, when I come home, there are the drugs. I look out my window and people are selling drugs.

Some of my best friends are on drugs, both Black and White.

I went out with a friend of mine on Saturday night—or Friday night, and I went into West Hartford, which I very rarely do because I stay in Hartford on the weekends. And she does drugs, and I did not know this.

And I do not do drugs because I feel like why should I waste my life; I have my whole life ahead of me. I do not have to do drugs to get high and to feel better about myself because I do feel good about myself.

And it makes no sense. And I see my friends who have money, who are rich and who can go to college, who have gotten accepted early into Yale, Harvard, Bucknell, Lehigh, and they do drugs on

the weekends but they have a 3.8 average in high school. It makes no sense, and I get angry.

The other day at my psychology class, there was a boy there, and he was bragging about how his parents put him into Mount Sinai, a hospital in Hartford, because they could afford to and how he craved a joint.

That enraged me because, at my house, there is a 42-year-old man who cannot even hold a job because he has done drugs for 25 years.

And, I mean, you guys, we are the future. We are the future. You know, it is something to just come to school every day; it is hard. It is hard to get good grades. And then you go home and you see guys about our age with blazers and Volvos—you know what I am saying—but you have got to be strong.

You have got to be strong because, you know, in 20 years, after you have gone to college and after you have gotten yourself established and you go back to your neighborhood, can't nobody take that away from you ever.

And when you have your children, you make sure and tell your children, "Yes, I have come from the projects and, yes, I have strived." And let them know what you have gone through.

I live it. I cannot convey to you guys what I live and what I see every day, but I am trying to break the cycle in my family.

My mother had me when she was 16. And I am trying to break the cycle. I am going to college, and I am going to make something of my life.

And drugs and alcohol, that gets you nowhere but dead. I see it and I live it.

And you guys see all those guys and girls with the big earrings and the clothes and the possessions, material possessions and things, that is nothing because, like I said, when you come back to your neighborhood in 20 years and you have things and you have your education, nobody can take that away from you ever.

[Applause.]

Senator DODD. I wish you had some strong feelings about this.

[Laughter.]

Senator DODD. I am glad you were nervous. I would hate to see you when you are not nervous. We will keep both statements of yours.

I do not know what you said in the written one, but if it comes close to what you said extemporaneously, then those words will be tremendously helpful. And I appreciate your candor and honesty.

In fact, I would like to talk to you maybe during a break about coming with me to some of the high school forums and having you sit there and listen to some of the things I hear and have you respond as well.

It could be a tremendous asset. I would like to chat with you about that.

Thank you for coming this morning. Are you missing class being here?

Ms. GILL. Yes. A psychology test.

[The prepared statement of Ms. Gill follows:]

PREPARED STATEMENT OF LATRICIA GILL

I live in two separate worlds. The first is the world of big expensive cars, furs, money, and prestige and the other is of dreams, hopes, poverty, and denial. My two worlds are divided into my school life and my home life. My school life and home life have a unique bond between them and that is drugs.

A few weeks ago during lunch, my friends and I got into a heated debate about who we are as Black women and how we were not going to become caught up in the drug society that is running rampant around us. Then I went to class and was confronted by another discussion. A discussion that two of my classmates were having about "going into Hartford to buy drugs."

It is a cycle, one that begins in the city and ends in the suburbs. I cannot remember how many times I have seen students from my suburban high school drive through my project "in the ghetto" and look for drugs. I really believe the cycle lives because of the dealers in Hartford and the buyers in West Hartford. I am not saying the dealers in West Hartford don't deal in Hartford. I am saying that at my school drugs is a problem that people make out as not existing.

I am a student in Project Concern, a program that buses inner-city students to suburban high schools and elementary schools. On the bus in the morning I see the young girls with the clothes and jewelery suplied to them by their drug dealing boyfriends. I see their eyes light up talking about what dealer has the most "status." I see that for them it is a big deal for them to have material possessions. In school in the afternoon, I see students who talk about their weekends and how much they smoked, snorted or have drank. A few days ago, I was in my psychology class and a fellow student was bragging about being on drugs and his parents putting him into the Mount Sinai Hospital drug and alcohol abuse clinic. He socffed at a movie we watched about marijuana and said he craved a joint. He also bragged about how he could jump on a bus and go into Hartford to get his drugs. This enraged me because I saw the innerdependence between Hartford and its suburbs. The young girls and the boy, somehow they fit together like pieces in a puzzle.

Senator DODD. Beverly Crane from Milford, Connecticut, is, again, a parent.

We thank you, Mrs. Crane, along with Mr. Calzetta and Mrs. Bernier, for being here this morning.

It is painful, I know, as parents, to talk about children and the problems at home, but we thank you for coming this morning to talk about your personal experience.

We would be glad to receive your testimony.

STATEMENT OF BEVERLY CRANE, MILFORD, CT

Mrs. CRANE. Thank you, Senator. I was asked to share some obstacles that presented themselves in us trying to get ourselves into rehab.

First of all, I should let you know that my son is 16 years old.

The first obstacle in our case was when we suspected a serious drug problem. We could not force him to have any urine or blood

tests to confirm our suspicions. Our hands were basically tied. There was nothing we could do.

But thank God for the help and cooperation of our doctor; our son did go for the testing.

Second, upon discovering that he was definitely on a multiple of drugs, because of his being 16, we had absolutely no say, there was nothing we could do to get him into a rehabilitation program unless he decided to go.

The only thing we could do, if anything, we were told, was if he were arrested; then, possibly, we could get a court order to send him to rehabilitation. This is because of how the laws read.

My son was arrested in the midst of all this going on for criminal mischievous behavior. So we tried to use this to our advantage to get him the help he needed.

It started by going to the District Attorney. We went to court and appeared before the District Attorney. I proceeded to tell him that my son's drug testing came back positive—and, at this point, it was unbeknownst to our son—with pot and cocaine.

I requested a court order for rehabilitation. The District Attorney stated very matter-of-factly that the arrest was not drug-related and, therefore, he refused a court order request.

I tried to explain to him—because at this point, my son was ranting and raving—that if my son were not on these drugs, he would not be behaving in this manner.

He continued not helping at all and told me to take my family squabble home. He was only interested in the arrest.

I tried desperately to explain that here were parents who were not closing their eyes to their child's problems and that he could help to straighten out a kid's life, and he just dismissed it.

After that, we saw another man to determine if my son would be charged as an adult or as a youthful offender.

My reply, of course, was "whichever way I can get him the help that he needs today".

Although he was very polite and sympathetic, he could not do anything, and he saw the major problem being that this charge was going to be on my son's record permanently, not a drug abuse problem.

I told him I did not care if it went on his record as long as he could get the help that he needed. He turned around and said that he would have to be tried as a youthful offender. So that was that.

Now we waited to go before the Judge to have this referred to the Youthful Offender Court and get a court date.

When our turn came to go before the Judge, she again was very understanding and talked to my son in a way to let him know that her hands were tied and that the only reason—and that was the only reason why she could not order him to go for rehabilitation, but granted our request to put him on probation with random urines mandatory to help keep him straight.

And she strongly advised him to get the help he needed. Again, it was because of the court system that she could go no further.

Fortunately, we convinced our son to go to Wakeman Hall for an evaluation, and this did not come easily. So that was our next step.

Once again, we were very fortunate. The very wonderful professional people at Wakeman worked with my son at his evaluation to

get him to see that he had a problem, and, so, he signed himself in. Again, as parents, because of the law, we had no say for his getting into this rehabilitation.

The last obstacle to deal with in his rehabilitation stay was that, once again, because of the law, my son could walk out or sign himself out at any given time during that 45 days.

This is a great temptation to a child because of all they have to face in rehabilitation.

Once again, the professional staff at Wakeman Hall helped see him through this.

Another problem that can be incurred is that, because of insurance policies, the time these kids can be put in rehab is limited.

At 45 days, we found with our son that the surface of his problems had just begun to be scratched. Had he been able to stay maybe 60 days, how much stronger he could have been to face society.

Now I understand that the stay is in danger of being cut back to 30 days. This is not long enough, especially when they have no halfway houses to facilitate them along. It is just back to society.

And what about the children whose parents do not have insurance or the money to have their kids in a rehab? To my knowledge, there is nowhere for them.

Of course, there is state aid. And how long does that take? Will it help in a crucial life and death situation? The time element is that grave; life or death.

My recommendations would be--first of all—mandatory drug testing. Parents should be able to have their children tested for drugs without the child's consent when substance abuse is suspected.

Also, I would recommend to encourage the court systems to work with concerned parents. Possibly, if it were mandatory for these court officials to take courses in drug and alcohol abuse and what it does and can to our children and families, this would help educate them to handle the program of substance abuse in a proper, profitable way.

I would also recommend that the laws be changed to work with the parent to help the child; not to give no control to the parent with a sick child.

Parents need more control in order to get their children the help they need, instead of leaving everything up to a 16-year-old who thinks he has all the answers but does not and whose thinking is clouded because of the substance abuse he is on.

How can anyone make a sound decision if they do not have a sound mind; not to mention a parent having more insight into life than a teenager has.

A teenager should not have to be arrested to get a shot at getting help. And, as I have shared, arrest does not begin to guarantee that help.

A teenager should not be left to his own decisions in this matter, as I also stated.

A parent should have the law's support to have that child put in a rehabilitation center for the child's own good.

There has to be a way in handling the time element in all these obstacles. As I stated before, it could mean life or death. My son

could be dead today if it were left to the ways of the laws and the courts, had we had to wait the three or four weeks until his youthful offender court date.

Possibly instant order of rehab after immediate drug testing results or at the very least mandatory evaluation that day in court and, if drugs are found, evaluation—if drugs are found and/or evaluation deems necessary.

If it involved turning a child over as a youthful offender it should be immediately, not in three or four weeks.

The time element should also work to the advantage of getting a kid into rehabilitation immediately if no police matters are involved also.

Today, my son is straight. I thank God for this, the people at Wakeman Hall, his family who was so supportive, and my son for accepting the help and support and letting God give him the strength to do it.

I cannot, however, thank the laws of our state or our court systems or the unqualified court officials who are amongst those that work in our court system.

I am also sorry for them, as I am for insurance companies that are more concerned for business matters and money than they are for people's lives and welfare.

Hopefully, changes will come through this committee and all those that play a role in trying to get the wrongs in our system made right so that our children get a fair shake at a full, healthy, long and wholesome life.

[Applause.]

Senator DODD. Thank you very much.

Let me tell you that I have heard what everyone has been talking about here, particularly about treatment.

But now I am going to open it up, as I said, in a unique senate hearing, I suppose, and let each of you maybe ask some questions of each other.

Obviously, there is a problem with long waiting lists. I raised this with you, Don, at the outset; if somebody wants to get into a program and get treatment, obviously, they have to wait five, six months. And that is just ludicrous; it does not make any sense to me at all.

I must say that we have fought hard with the drug bill last year. We changed the ratios. It used to be 40 percent treatment and education and 60 percent of the funds were spent on interdiction and criminal offenses and the like.

We changed the formula and ratios and it is now 60 percent in education and 40 percent on the other side.

But the problem is, you see, you do not get the same amount of coverage in a treatment program that you do, obviously, discovering a kilo of heroin some place; that is the big news.

So we have not been able to be as effective as yet in getting more dollars available.

There is the poor coordination, mix of coordination between inpatient and outpatient treatment programs—your point, Mrs. Crane; that a young person under 16 has to be the one to place himself in a treatment program or take himself out is mind-boggling, that a 14-year-old would be the one to make that decision and, even if

they had enough sense to get in, that they could then voluntarily take themselves out of it. When there are serious substance abuse or addictive problems, that is a major problem.

The inadequate insurance issue, I think, is appalling, given the endemic nature of this problem; that we do not have a greater degree of sensitivity on the part of the industry when it comes to this problem.

And last—but not least, of course—poor government, while it is true that maybe we should list it first, but poor government allocation of resources in terms of treatment as a priority, I mentioned that a moment ago. That is a problem.

I thought it might be helpful here if maybe some of the parents would like to ask some of the people in the various agencies—I was curious about one point that you were making, Ronnie, and that is about the coordination, working with the schools.

We do, of course, since 1986, a state law that requires that public schools have a curriculum relating to substance abuse from K through 12.

I have been told that there is not a single school, in your estimation, that is in compliance with that.

Not a single school?

Ms. SKERKER. Not a single school has a K through 12 drug abuse prevention program, not a single school, any school or school district in place today.

But to make the situation a little bit worse, we had a law in Connecticut passed in 1969 that mandated every child be taught about drug education, every year, K through 12. And after 20 years in the State of Connecticut, we still do not have a school system that is doing it.

Senator DODD. Not one single school?

Ms. SKERKER. Not one single school. Now, part of that is denial, a good part of that is denial.

A second part of it is what you suggest in terms of the Federal Government. What superintendent wants to get up in front of his constituents and say, "We have to put drug education in the school system because we have a problem." It is much nicer to increase SAT scores, and it is much nicer to have a music program where they tour Europe.

Those are the kinds of things that bring notoriety to a school system. The kind of notoriety a good drug program brings to a school system nobody wants.

I have to say that that is one of the reasons why I work so closely with John in his Regional Youth Substance Abuse Project, because six superintendents can get up and say, "We have a problem with safety" and one superintendent has a problem with that.

As I suggested in my testimony, even with the state drug law, I still have superintendents who will not put in a program.

I had a school phone me on Friday that is withdrawing their application for Bergen School District, withdrawing their application, turning down $12,000, because they refuse to put a program in for drug and alcohol education, Grades 11 and 12. They would rather turn down the money than put a program into place because their kids "do not need it", quote, unquote.

Senator DODD. Let me open it up here to anyone who wants to raise any questions based upon the testimony.

Ms. WRIGHT. Well, I know that in our high school, our students take health education in the 9th grade, and that is about it for their high school years.

Senator DODD. Why is it—I mean, I raise the question. I realize it is difficult to lay on the school systems all of this. There has got to be parents, the minister, the parish priest or the rabbi. There have got to be the local police officers. And when we overload a system, that is one of my fears.

But when we look at these educational programs as part of the seamless garment of education, instead of having the 15 minutes, when you get someone like me stand up at a high school and say, "Drugs are bad. You should not do drugs.", and you have the end of that 15-minute period, people go back to their normal classes—why is it not part of the history program?

Drug and substance abuse is not new. Historically, we have seen it in societies, in civilizations throughout time where it has been a problem.

Why are we not able to weave that into, say, math and science classes? I mean, there is a fascination with this among young people anyway. "What are the problems?" "Why are some of the substances addictive?"

Why could we not weave that type of thing so that it is part of the learning experience beyond a Monday morning forum at 9:15, when "we have covered it for this week"?

I mean, they are not even doing that, you are telling me. Why is it that we cannot sort of weave it into that system?

Dr. HIGGINS-BIDDLE. Senator, that would be, by far, the best way that this subject matter could be taught in our schools.

It is also the most difficult to accomplish.

Senator DODD. Why?

Dr. HIGGINS-BIDDLE. It is difficult to accomplish because this is a very difficult subject matter for teachers to understand, learn and be able to teach with some degree of comfort.

It is one thing to teach a kid that two plus two equals four. That is not going to challenge Johnny's life. To talk about alcoholism, when Johnny's—or, one of Johnny's parents is an alcoholic is a very difficult thing—or, when the teacher's parent or when the teacher is an alcoholic.

One in four of our children come from an alcoholic home, and that is true of our teachers as well.

We had, within the last two months—I think it was in January—we had the psychologists from one of our school systems in for training.

These are all people with advanced degrees. They were in tears dealing with their problems, with their parents' problems, with their kids' problems over drugs and alcohol.

And, yet, at the same time, the administrations of the schools are saying, "How can we get people out for three full days of training" or, in the case of a curriculum, "four full days of training that they ought to have to be prepared to teach this? That means somebody else has got to be in that classroom. That means four days of substitutes."

That is not only expensive, but it is harmful to the kids. The kids ought to have their teachers here. This is a tough problem; I agree with you entirely.

I mean, you ought to run for Czar of Education because integrating the subject in all of curriculums is the real answer long term, but it is a very difficult thing.

Senator DODD. With all due respect, you have got vacations, you have got summertime programs; there are a lot of ways which—I gather teachers are interested in this. I mean, they are the ones that are going to teach these kids.

I am sure there are some who would moan and groan about taking some time in the summer or taking some time away from spring vacation, a couple of days, but I gather most of them would welcome the opportunity to do it.

I do not know a single person that has not had a parent or a brother, an aunt, an uncle involved in a mental health program. Well, we have got to get over that. We have got to get over the feeling that we cannot discuss something because someone in somebody's family had a problem with it. I mean, we have got to break that cycle.

I mean, I hope those barriers have been broken down, although, frankly, I think they have not been.

Mr. LYNCH. In an attempt to be positive, I think I would like to talk about one thing that maybe is working in this area.

I think you saw an example of it just here today when our student here was talking to the students, and you saw the response that she received. It was a much more direct response than any of us had.

And in our Branford project, we are doing the same thing in terms of education.

Two years ago, through the efforts of the Students Against Drunk Drivers Program, our students from Wakeman Hall went to Branford High School and began to do some peer counseling and community awareness.

In a part of their recovery program which, at some point, is the ability to get back—or, give back what they receive, they went out there. And they had such a positive response from the student body that the students, themselves, pressured the school system to have them come back and come back and come back.

From that project led to the establishment of the Wakeman Hall Satellite Program in Branford. But I need to say that it was initiated by the kids and the parents and the school system.

And that is one that is working.

Senator DODD. My experience, again, has to do with the anger level. And I just find this over and over again; people get upset about something and then things happen.

Anything else?

Ms. WRIGHT. I think the decision has to come from the top in terms of the superintendent to make a decision because, as we all said, we are aware that there is definitely a problem.

The teachers and staff members have to be trained. From my experience, we are definitely not trained to deal with this. And if you are not trained to deal with it, I do not think that the folks are going to be doing an adequate job. So the training is the first part.

And, I believe, within each school district—there are days, I know, when we have in-service days. But it can be implemented.

And, certainly, in part of the science curriculum, I believe it can be included.

Senator DODD. Why do you not get Latricia to come and give a talk for half an hour?

I mean, I presume, like other teachers, when it is an in-service day, it is a yawn; it means you have got to go through there, sit down and listen to some so-called experts about how you ought to be conducting your business.

Now, I have a sister who is teaching in the Hartford public school system, and she has taught for 30 years. My aunts taught for 25 years at Hartford High, Westhaven High, Windham High; three of them. They taught a generation ago.

Ms. WRIGHT. I am not sure that it is as difficult as we like to make it out to be. I believe that there is fear and reluctance on our part because it is a fact that a lot of our students know more about drugs than we do.

I mean, they can certainly tell you whatever it is you want to know about it.

And we have to become more knowledgeable about drugs and work on our mode of delivery.

Ms. GILL. I know in West Hartford that the people that began our organization of S.A.D.D., they drink, Students Against Drunk Driving. And they drink.

And it is like—our teachers there—I have one teacher in particular—well, two teachers in particular who will sit down and take the time in their classes to talk about drugs and alcohol and different things like that, things that are affecting us.

But other teachers are just not too concerned because, like they were saying, two plus two is four, you know, divided by two is one.

And I do not really think that they want to spend their summers in times like that learning about drug education. Like you said, they have to get mad and, before they get mad, I do not think it is going to get done.

Senator DODD. Don?

Mr. MCCONNELL. I would just like to say that I know we are talking about school and teachers, and I do not deny any of the help that has been stated to be needed.

What we have is this problem throughout our society. There is no training in medical school, for instance. We do not have a pediatrician with any knowledge better than the parents.

We have other people in education somewhere along the line who are involved, but there is certainly no training in our clergy for this, and there is no training for parents along the line.

We try to put courses in medical school so that someone getting an M.D. would know something about addictions so they could make a distinction between what they prescribe and people becoming dependent on some drugs and those who are addicted.

Well, dependency can also be addiction. A lot of women are addicted today to valium because of prescriptions. And then how do they get them off that? It is a whole other story.

So what I am trying to say is that we are not using the education media, not only our schools or our universities but, as I mentioned before, the television.

I mean, if we do not, some how or other, control that mass media, then it will educate our people the way it wants. And, right now, it is in the hands of the National Advertising Association, the National Broadcasting Association and however commercial television wants to make its money.

Senator DODD. I think it was you, Amy, who talked about commercials on television—or, you did, Don; I apologize.

Mr. MCCONNELL. That is one of my pet peeves.

Senator DODD. They even want to talk about some labeling or something. And I want to tell you that you are absolutely correct. It is not the manufacturers. It is major bucks.

When you are talking about the cost of programming, you start taking off a Budweiser—and I do not pick out Budweiser in particular, you can pick any one that you want—you are hitting a hot button, let me tell you.

Mr. MCCONNELL. Let me pick one, if I might. Let me pick Coors.

If you look at what Joe and Bill Coors are doing, they are putting a little money in student assistance programs, national organization student assistance programs, a few dollars; maybe a couple of thousand, maybe 10 thousand.

But look what they do with E.T.? And this is a subtle message with your Students Against Drunk Drivers that were talked about.

The subtle message is they want to get to controlled drinking, and they are focusing on kids.

We talk about high-risk kids. They know who the high-risk kids are better than we do. So what happens to Coors? What did E.T. in the movie get drunk on? What was in that refrigerator? And what do you think Coors paid for that?

It was Coors beer right on the screen that E.T. got drunk on. And what does the sleezebag do after that? He comes out with a poster with E.T. and they light his finger up: If you are going to drink, do not drive. Phone home. Nice message, right? Underneath, it says, "Coors Beer".

There is something diabolical about this that we have got to hit every governor in the country on and maybe the senators, too.

I got something from Seagram's a week or two ago in regards to responsible drinking.

And what Seagram's has done over 57 years—there is a very subtle battle going on between those who want to prevent substance abuse and those who are pushing drugs. Alcohol is a drug.

I think our big pushers are not on the street corners. I think our big pushers are on television. And that is forming an attitude, and that attitude is a revolution that we need to change. We need to change this attitude. We need this revolution.

Ms. SKERKER. Senator Dodd, I just want to touch on one other comment. Don and I, of course, worked together, and this is a battle that we both fight.

They offer us money. And we have no money. And they call and say, "We will give you 15 grand, but we want our guy, Jim Coors, to come out and hand out an award." And I had to turn that

money down because I had a problem accepting money from people who are selling drugs. And, clearly, they are selling drugs to kids.

Their pitches are very good. One of the interesting things I saw is they took MASH; everyone loves that TV show. When you really look at what is going on on that show, it is drinking all of the time.

And they cut out all of those segments on drinking on MASH and showed it to 3rd-graders and asked, "What would you offer to someone to drink when they come to your house?" Some people said milk and juice, and a couple said beer. The majority said non-alcoholic beverages.

They then showed another group—the same socio-economic level of 3rd-graders—the uncut MASH shows, and then asked the kids, "What would you serve somebody if they were thirsty?" And 97 percent of the 3rd-graders said "liquor". So, you can see that subtle message on a very nice show.

We are not talking Dynasty time. We are talking about nice, family entertainment. And I think we really have to look at that.

There is one other thing I have to point out that I am appalled and terrified of: the suicide rate in Connecticut. And I have had to do damage control for staff.

There was one school system, a suburban school system, not an urban school system, that had five completed suicides in six months in a school system of 500 children. Each one of them was a boy; they did not know each other. They had all been arrested for drunk-driving first, which is a very common modality. And every single one of them killed himself with a handgun.

And you want to talk about advertisers and who is pushing things? We have to look at gun control. Our young kids in this town, this state, are killing themselves in suicides with handguns. You shoot deer in Western Connecticut with a handgun. The guns and the booze together make for a deadly combination.

Senator DODD. Yes, Mrs. Crane?

Mrs. CRANE. I might have missed something here, but why do we only have one person in Ms. Skerker's position and what can we do to get more?

Senator DODD. I tried to make the case when I introduced her. First of all, I am going to tell you, we all happen to be deeply interested in the subject. We have been deeply affected by it as parents. Whether it is a student or a principal or people involved in programs around the country and in the state in research, involved in commissions or with commissioners, the government, the state legislature, there are others making decisions about where priorities ought to be, where you put dollars.

So it is easy enough for us to sit here and say, "If you and I were running the shop, we would put more in this particular area."

So in fairness to them, they have decided that resources should be spent in other areas.

There are just a couple of other points I would like to make. I just want to tell you that, as a politician, politicians pay attention to angry constituents; they do not pay attention, generally, to the ones who are not angry. Until people absolutely get livid about the subject, nothing is going to happen.

I had 3,000 phone calls on John Tower. I wish I could get 300 calls on drugs. I had those 3,000 calls about one guy; ironically, it was related to the accusations that had to do with substance abuse.

But, nonetheless, the fact that 3,000 people in the state could get so upset about this guy that they would call my office—I wish the day would come when someone called and screamed at me because the senate and the congress and the President of the United States are not doing enough to rid this country of a scourge; booze as well as drugs. And we do not get anything like that.

Mrs. CRANE. So what would you suggest?

Senator DODD. Latricia, you should go out. Mr. Calzetta should go out. You are parents. You have got to go out. You are not specialists in this area, but you bring to it a unique special insight.

Mr. CALZETTA. Maybe through the S&L's that are going bad, that could be where we get the money that we need.

Senator DODD. Sure. No one has said to me, by the way, "We are going to give $160 million to bail out the S&L's."

Mr. CALZETTA. What, is the budget $15 million less this time than it was in 1986 for drugs?

Senator DODD. Well, I have forgotten the exact number—Mr. Calzetta. And this is from a President that said we were going to eradicate the scourge.

Senator DODD. Well, I think he really does want to make an impact, and Mr. Bennett has appointed at czar and gotten people in place.

The people in congress really want to do something about it. I believe that. I think we are not arguing the question about whether or not we should.

It is a question of whether or not—well, we are not going to solve this problem overnight. Americans have a tendency, once a problem has been identified, to want it solved yesterday. And this is not one that is going to be solved yesterday.

Mr. MCCONNELL. Senator, I would just like to say that the czar will not talk about alcohol. He will talk about illicit drugs.

And I think that message, if it is going to come out of the White House, is that alcohol is number one with these kids.

Senator DODD. I think we lost 150 or maybe 200 kids, maybe not even that much, to drug overdoses nationwide in our school system.

Now, again, that is not a pleasant number to cite, but we are losing 17,000 to 20,000 people in this country every year to alcohol-related accidents in automobiles.

Ms. SKERKER. Statistically, if you take every man, woman and child over the years of 14, 50 gallons of beer are drunk per person in the United States, 50 gallons of beer for everyone over the age of 14. And those are old numbers.

Senator DODD. Connecticut ranks 20th in the Nation for per capita consumption of alcohol.

Ms. SKERKER. Do you know what is number one?

Senator DODD. Yes. Washington, D.C. But I wonder if that would correlate to any one socio-economic group at all.

Dr. BABOR. It is tourists and people coming in entertaining. Washington has a high per-capita consumption because of all the people coming in and entertaining, and the tourism.

Nevada has a high per-capita consumption as well because of Las Vegas.

Senator DODD. That would explain Washington?

Dr. WHEATON. Do not draw any direct relationship between the two cities.

Senator DODD. You have all been extremely patient this morning to take an entire morning out. It is now actually not morning but afternoon.

And, after this, we are going to go over to your child center. I know a number of you are going to be joining us for lunch and a visit at that particular facility.

I will see that my colleagues on the committee and the senators get your comments and your statements you have made here this morning as a part of the record.

We would like to take some of these suggestions. I am sure we will—or, I know we will, in fact, on some of the appropriations bills this year and authorization programs, discuss the problems and see if we cannot begin to redirect some of these resources. It is a battle.

I did not even get into early childhood development issues. As Dr. Ziegler at the Bush Center at Yale, I am convinced that if you get involved in early childhood development programs and parents can be involved with those children early on, what a difference that would make in reducing the potential of these problems.

So I thank all of you for being here this morning. If any of you have any additional pieces of information that you would like us to have, please do not hesitate to get it to us.

And this Subcommittee of the Labor and Human Resources Committee will stand adjourned until further call of the Chair. Thank you.

[Whereupon, at 1:00 p.m., the Subcommittee adjourned, subject to the call of the Chair.]

○